Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Montana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**
Montana Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver

C. **Waiver Number: MT.05**

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
08/01/11

Approved Effective Date of Waiver being Amended: 10/02/07

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
One of the purposes of this amendment is to update the provider qualifications of the Family Support Specialist (FSS) to include that the FSS has a Bachelor's degree in human services OR has three years direct experience (as documented by the agency) working with youth with Serious Emotional Disturbance. The agency that provides FSS services must ensure that the FSSs receive clinical supervison. The second purpose of this amendment is to change the unit definition of Education and Support Services from "per series package" to "per session". The change in the unit definition is not anticipated to increase expenditures due to the initial projections and the actual utilization of the service.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	

Component of the Approved Waiver	Subsection(s)
☑ Appendix C – Participant Services	C-1/C-3
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☑ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Change the unit of service for Education and Support Services form "per series package" to "per session".

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Montana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Montana Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver

C. Type of Request: amendment [PRTF Demonstration Grant]

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **MT.05.01.16**

D. Type of Waiver *(select only one):*
Regular Waiver

E.
Proposed Effective Date of Waiver being Amended: 10/01/07
Approved Effective Date of Waiver being Amended: 10/02/07

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

☑ **[Demonstration Only] Psychiatric Residential Treatment Facility (PRTF)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the PRTF level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Title: Montana PRTF Demonstration Waiver

Purpose: The Psychiatric Residential Treatment Facility (PRTF) Waiver for Youth with Serious Emotional Disturbance (SED)[1] will provide Montana with the ability to provide home- and community-based services for youth who meet the criteria for PRTF level of care, using a community-based wraparound service delivery model. The services under this Waiver were designed to provide youth with SED the choice between receiving services in a home- and community-based setting or in a PRTF. The Waiver will allow flexibility, both as a conceptual service delivery model and as a unique package of service. Services will include home-based therapy coupled with a customized package of services (e.g., Home-based Therapy, Customized Goods and Services, Non Emergency Transportation, Consultative Clinical and Therapeutic Services, Education and Support Services and Respite Care, Wraparound Facilitation, Family Support Specialist, and Caregiver Peer-to-Peer Support). The package will be designed by the youth, the family, the therapist, the plan manager, and the wraparound facilitator and will be structured to provide the supports needed to safely maintain youth in their communities.

An eligible youth, who is age 6 through 17, must have a diagnosed SED, meet level of care criteria for PRTF, and reside in an area of the state where the Waiver services are available. Level of Care (LOC) for PRTF is the criteria set forth in 42 CFR 441, Sub part D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs and in Montana's Administrative Rules which defines the Inpatient Psychiatric Services, Certificate of Need, Utilization Review and Inspection of Care. This project will provide for wraparound, youth- and caregiver/legal guardian -centered services and supports needed to maintain 100 youth with SED in their communities. The waiver application is consistent with HCBS quality framework. The PRTF Waiver stresses the importance of respecting the preferences and autonomy of waiver participants.

Goals and Objectives
Goal 1. Offer youth with SED the choice of HCBS. These numbers are for any point in time.
a. Within Waiver Year 1, Enroll and track 20 Yellowstone County youth with SED.
b. Waiver Year 2: Enroll and track 30 in Missoula and Ravalli Counties; Wavier Years 3 – 5 Enroll and track 50 youth in, Lewis and Clark, Cascade and Flathead counties. This amendment for Waiver Year 3 will add surrounding counties to the following Core County Sites: Yellowstone: Carbon,Stillwater, Musselshell and Big Horn, and, Lewis and Clark: Broadwater and Jefferson. A total of 100 youth will be served.
c. Measure success through functional outcomes, cost effectiveness, consumer surveys and cost neutrality

Goal 2. Ensure the availability of wraparound, culturally competent, participant centered HCBS for youth with SED.
a. Strengthen the local multi-agency teams that exist
b. Create waiver participant-centered Wraparound Teams while avoiding duplication of efforts

Goal 3. Engage waiver participants in system design
a. Define mechanisms to ensure that participant and provider feedback reaches administrators, management, utilization review and evaluation contractors.
b. Encourage and assist waiver participant participation in the Administrative Rules of Montana (ARM) rule making process.

Organizational Structure: Montana PRTF Demonstration Waiver Is the responsibility of the Department of Pubic Health and Human Services (DPHHS),the state Medicaid Agency, and will be managed within the Children's Mental Health Bureau, Developmental Services Division. The MT PRTF Demonstration Waiver Project Director will oversee day-to-day operation, project staff and service providers. The Project Director will work with state and community-level partners.

Service Delivery Methods: The Wraparound Service Model will be used. This planning process follows a series of

eligibility steps. Once approved the Plan Manager will refer the youth to the Wraparound Facilitator. The Wraparound facilitator will coordinate and facilitate a Plan of Care within 10 working days of receipt of the referral. Services will be provided through a Wraparound team that includes the waiver participants. The team assures that participants' needs and the entities responsible for addressing them are identified in a written individual Plan of Care. The services provided to youth with SED are highly individualized and as comprehensive as possible.

Transition Plan for youth in year five of the PRTF Demonstration Project: Youth receiving PRTF services in the fifth year of the grant who will need continued services will be transitioned into the waiver services. In the event the waiver is discontinued, those youth will be transitioned to State Plan Services including in-patient residential treatment facility services. The State envisions there will be close contact with our federal contacts at CMS who will provide guidance prior to the conclusion of the demonstration project. Other grant avenues, if presented, will be considered.

1. The target group must: 1) meet the criteria for "Serious Emotional Disturbance" as defined in the Administrative Rules of Montana ,2) be Medicaid-eligible; 3) be between ages of 6 through 17; 4) demonstrate such complex health and mental health needs that they require ongoing residential treatment or are at imminent risk of admission to a PRTF; 5) be able to remain in their communities given availability of an appropriate package of services designed to address multiple needs; 6) have a viable, consistent living environment with parents, legal guardians or caregivers who are able and willing to participate in the Montana PRTF Demonstration Waiver project and maintain the child in the community. Additionally, the target group must live within the geographic service areas for the Waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ( ) **No**
- (●) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☑ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

1. Offer youth with SED the choice of HCBS. These numbers are for any point in time.
   a. Within Waiver Year 1, Enroll and track 20 Yellowstone County youth with SED.
   b. Waiver Year 2: Enroll and track 30 in Missoula and Ravalli Counties;
   c. Wavier Years 3 – 5 Enroll and track 50 youth in, Lewis and Clark, Cascade and Flathead counties.

This amendment for Waiver Year 3 will add surrounding counties to the following Core County Sites: Yellowstone: Carbon,Stillwater, Musselshell and Big Horn, and, Lewis and Clark: Broadwater and Jefferson. A total of 100 youth will be served.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records

documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I.**

D. **Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C.**

E. **Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The Children's Mental Health Bureau relies on the use of local multi-agency teams that include family members, providers and child-serving agencies needed by youth with SED and their families. These teams may include the Kids Management Authorities (KMAs). KMAs are comprised of representatives of child-serving agencies, juvenile justice, schools, other stakeholders,families and youth. These teams provide a valuable conduit for informed public input for the waiver, particularly at the local level. Input from the KMAs and other stakeholder groups will be elicited in a series of steps, beginning with hosting a facilitated session that brings local stakeholders together to provide input on planned waiver services and strategies.

A number of steps have already been taken to elicit public input using METNET, a telecommunications delivery system with the capacity to link communities in real-time. Public input to Children's Mental Health Bureau Regional Program Officers in local areas has been taken into consideration, as have the results of a statewide survey designed to collect provider and consumer opinions on services needed. Children's Mental Health Bureau (CHMB) staff have also met with local providers in Yellowstone County to discuss the PRTF Waiver and to discuss services and service capacity. CMHB staff will meet with local providers in areas in state where the waiver will be expanded.

Engaging families helps ensure that systems are effective. Additional mechanisms will include eliciting feedback through additional METNET meetings. Administrative Rules of Montana have been proposed and will be amended to include new sites and services, as part of the state's required review process, a public hearing will be held to provide information about the waiver and to solicit oral and written comments before the proposed rules are finalized. Families and other stakeholders have been, and will continue to be, encouraged to participate.

The Children's System of Care Planning Committee (SOC) was established by statute in 1993 (52-2-303 MCA) to develop and coordinate an integrated service support system for children under age 18 who are seriously emotionally disturbed (SED), living in or about to be placed in an out-of-home setting, and needing the assistance of more than one state agency. The committee is made up of about 30 members who represent parents of seriously emotionally disturbed youth, SED youth, Native Americans, advocacy groups, mental health providers, and state agencies that serve young people in some capacity. The Director of the Department of Public Health and Human Services appoints the members. The SOC Committee also provides a valuable mechanism for eliciting opinions from a state-level perspective.

The Department has notified in writing all federally-recognized Tribal Governments regarding the intent to submit an application for a home and community based services waiver. Tribal entities were notified officially on May 1, 2007 and were provided the opportunity to submit their comments and views. The Department offered to meet with Tribal entities at their request.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Dalton

First Name: Mary

Title: Branch Manager

Agency: Department of Public Health & Human Services,

Address: P.O. Box 4210

Address 2: 111 N Sanders,

City: Helena

State: **Montana**

Zip: 59601-4210

Phone: (406) 444-4084 **Ext:** ☐ **TTY**

Fax: (406) 444-1970

E-mail: mdalton@mt.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Adee

First Name: Bonnie

Title: Bureau Chief

Agency: Department of Public Health & Human Services, Disabilities Services Division, Children's M

Address: P.O. Box 4210

Address 2: 111 N. Sanders, Room 307; PO

City: Helena

State: Montana

Zip: 59601-4210

Phone: (406) 444-1290 **Ext:** ☐ **TTY**

Fax: (406) 444-0230

E-mail: badee@mt.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Last Name: Dalton

First Name: Mary

Title: State Medicaid Director

Agency: MT Department of Public Heath and Human Services

Address: PO Box 4210

Address 2: 111 N Sanders

City: Helena

State: Montana

Zip: 59601

Phone: (406) 444-4084

Fax: (406) 444-1970

E-mail: mdalton@mt.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medicaid Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Developmental Services Division Children's Mental Health Bureau
(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a)Children's Mental Health Bureau is responsible for the design, implementation, and monitoring of all activities associated with this waiver.
   b)There is no single document serving to outline the roles and responsibilities of all staff related to waiver operation. The Plan Manager's and the Program Director's Position Descriptions details the roles and responsibilities of these position regarding the waiver. The waiver application is the authoritative document serving to outline the person's/positions responsible for ensuring all the requirements of the waiver are met. In addition the administrative rules of Montana outline the roles and responsibilities of providers.
   c)The Medicaid Director, or designee, are ultimately responsible for ensuring that problems in the administration of the waiver are resolved. The Medicaid Director, or designee, are not directly involved in the day-to-day operational decisions. The Medicaid Director or designee, receive copies and approves the waiver or renewal or amendments prior to submission to CMS.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Megellan Medicaid Administration Inc.(Megellan) will complete Psychiatric Residential Treatment Facility (PRTF) reviews to determine if the individual meets level of care requirements for enrollment in the Waiver

program. Pre-Admission determination involves screening youth to ensure: that the youth meets criteria for Serious Emotional Disturbance; that the youth meets Certificate Of Need requirements for an institutional level of care; meets the criteria for medical necessity; meets the other criteria established for participation in the PRTF Waiver; and resides within an area where operation of the Waiver is in effect. Megellan will review clinical information received from community providers based on established protocols for a PRTF level of care. This contractor will also do reevaluations every twelve months, or at the request of the plan manager if significant improvement is noted.

Affiliated Computer Services (ACS) serves as the full fiscal agent for the State's Medicaid program. It will process Medicaid claims and assist Waiver service providers with enrollment.

An agency or licensed mental health professional who has completed the wraparound training and is certified and/or working toward certification, must enroll as a Medicaid provider in accordance with Appendix C, and concurrently contract with Children's Mental Health Bureau. The contract serves to protect the wraparound fidelity. Freedom of choice requirement applies and the State will not limit. The wraparound facilitator within ten working days of receipt of referral will coordinate and facilitate a Plan of Care meeting with the Wraparound Team.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Developmental ServicesDivision/Children's Mental Health Bureau is responsible for assessing the performance of any contracted entities involved in conducting Waiver administrative and operational functions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Megellan Medicaid Administration will submit a Management Report to the Developmental Services Division of the Department of Public Health and Human Services on a quarterly basis. The report will capture data on the date of level of care assessments, the outcome of the assessments and days elapsed between the request for level of care determination and the date the letter was sent to the applicant family notifying them of the level of care determination outcome. The Children's Mental Health Bureau (CMHB) will monitor the report to ensure that assessment and information regarding level of care determination is provided in a timely manner. The CMHB will periodically review a sample of level of care determinations to ensure accuracy and consistency in the application of the level of care instrument. All level of care denials will be sent to the CMHB for review. Assessment of the contract agency's performance is part of the quality assurance process.

Affiliated Computer Systems (ACS) submits a monthly Report Card that summarizes the internal monitoring ACS does over the system and processes (i.e. recipient subsystem, provider enrollment, claims processing and documents, verify changes requested for codes were made appropriately). The MMIS coordinator and senior Medicaid policy analyst meet with ACS weekly to discuss progress and/or problems with system updates. Monthly status meetings are held between the CMHB, other Department of Public Health and Human Services staff and ACS staff. In addition, ACS completes internal audits to review their system processes and effectiveness as a contractor. This information is shared with the state in the form of a Service Auditor's Report. ACS also completes an annual SAS 70 internal audit.

Developmental Services Division/Children's Mental Health Bureau is responsible for assessing the performance of the contracted entities for the provision of Wraparound Facilitation Services.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☐
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐

Function	Medicaid Agency	Contracted Entity
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Megellan Medicaid Administration will complete a PRTF Level of Care within two days of receiving the referral. The numerator is the number of youth who received LOC determination within two working days. The denominator is the number of youth who were referred for LOC determination.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Management report sent from Megellan Medicaid Administration to the state. The state will validate information by a record of review of the Plan Manager's file.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Affiliated Computer Services (ACS) will set up a PRTF Waiver Plan of Benefits file for youth enrolled in the Waiver. Information is submitted to ACS from the county Public Assistance Office via a form documenting the youths enrollment date. The numerator is youth enrolled in PRTF Waiver with a Plan of Benefits file. The denominator is all youth enrolled in the PRTF Waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS reports depicting enrolled youth with a Plan of Benefits file compared to the states data base listing all enrolled youth.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☑ Monthly	☐ Less than 100% Review

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The wraparound facilitator will coordinate and facilitate a Plan of Care meeting within ten working days of receipt of a referral. The numerator is the number of referrals who have a Plan of Care Meeting within ten working days of receipt of referral. The denominator is the number of youth referred to the facilitator.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State will meet with all contractors not performing the duties and expectations defined in their contracts. The State will request a report explaining why there is a deficiency and the contractors corrective action plan. The State will negotiate a time frame for resolution of the problem.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
◉ Mental Illness					
	☐	Mental Illness			
	☑	Serious Emotional Disturbance	6	17	

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The target group must: 1) meet the criteria for "Serious Emotional Disturbance" as defined in the Administrative Rules of Montana.; 2) be Medicaid-eligible; 3) be between ages of 6 through 17; 4) demonstrate such complex health and mental health needs that they require ongoing residential treatment or are at imminent risk of admission to a PRTF; 5) be able to remain in their homes and/or communities given availability of an appropriate package of services designed to address multiple needs; 6)have a viable, consistent living environment with parents, guardians or caregivers who are able and willing to participate in the PRTF Demonstration Waiver and maintain the child in the home or community. Additionally, the target group must live within the geographic service areas for the Waiver.

SERIOUS EMOTIONAL DISTURBANCE *(For the PRTF waiver, only the clinical criteria applies. The age eligibility is 6 through 17).

Serious emotional disturbance (SED) means with respect to a youth from age 6 through 17, that the youth meets requirements of (a), and (b).

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:
(i) childhood schizophrenia (295.10, 295.20, 295.30,295.60, 295.90);
(ii) oppositional defiant disorder (313.81);
(iii) autistic disorder (299.00);
(iv) pervasive developmental disorder not otherwise specified (299.80);
(v) asperger's disorder (299.80);
(vi) separation anxiety disorder (309.21);
(vii) reactive attachment disorder of infancy or early childhood (313.89);
(viii) schizo affective disorder (295.70);
(ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x,296.5x, 296.6x, 296.7, 296.80, 296.89);

(x) obsessive-compulsive disorder (300.3);
(xi) dysthymic disorder (300.4);
(xii) cyclothymic disorder (301.13);
(xiii) generalized anxiety disorder (overanxious disorder)
(300.02);
(xiv) posttraumatic stress disorder (chronic) (309.81);
(xv) dissociative identity disorder (300.14);
(xvi) sexual and gender identity disorder (302.2, 302.3,302.4,
302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
(xvii) anorexia nervosa (severe) (307.1);
(xviii) bulimia nervosa (severe) (307.51);and
(xix) intermittent explosive disorder (312.34)
(xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.
(b) As a result of the youth's diagnosis determined in (a)and for a period of at least 6 months, or for a predictable period over 6 months the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:
(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;
(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;
(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;
(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;
(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or
(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The youth becomes ineligible when s/he turns 18. When the youth reaches age 17, the wraparound treatment team will begin developing a transition plan of care. The youth will be evaluated to determine the services needed as well as the appropriate service delivery models. Montana PRTF Demonstration Waiver service providers, the family, the youth and the Wraparound Teams will work together to create an individualized transition plan. If continued services are indicated, the individual will be connected to appropriate community services, including regular state Medicaid treatment services as medically appropriate. The services included in the transition plan may include some of the supports the youth has already connected with. Six months prior to discharge, as appropriate, the wraparound team will gradually begin adjusting the frequency of contact and begin introducing the youth to the identified alternative providers until contact is phased out and a positive, seamless transition has been achieved.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

A comprehensive assessment and review of the service records will be used to identify the formal and informal service needs of the youth in context with provider capacity and availability. The State reserves the right to refuse enrollment in the Montana PRTF Demonstation Waiver project if the Plan of Care cannot reasonably assure the health, welfare and safety of the individual. Additionally, the State can refuse to accept a youth even if s/he otherwise meets the criteria for the target population, but has a co-occurring medical or other condition (e.g., cancer) that would signficantly raise the cost for Medicaid care to a cost above 100 percent of the intistutional cost. The youth and legal guardians would receive appropriate notification of appeal rights.

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

Prior to enrollment in the PRTF Waiver, youth/legal guardian is advised that at such time the health and safety of the youth cannot be met within context of the waiver cost parameters and/or home and community based service model, s/he will be discharged from the waiver to regular Medicaid state plan services. At that time, the best course of treatment for the individual youth will be determined and the youth will be placed accordingly, whether in psychiatric residential treatment or another treatment modality available through the regular medicaid state plan or another appropriate waiver(e.g. physically disabled waiver).
The average length of stay (LOS) is not capped. The Plan Manager will evaluate the annual budget per enrollee and the overall cost neutrality to determine whether the individual enrollee's length of stay can be financially supported.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	20
Year 2	

Waiver Year	Unduplicated Number of Participants
	40
Year 3	100
Year 4	200
Year 5	200

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	20
Year 2	25
Year 3	100
Year 4	100
Year 5	100

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entrants to the Montana PRTF Demonstation Waiver project must: 1) meet the clinical criteria for "Serious Emotional Disturbance"; 2) be Medicaid-eligible; 3) be between the ages of 6 through 17; 4) demonstrate such complex health and mental health needs that they require ongoing residential treatment or are at imminent risk of admission to a PRTF; 5) be able to remain in their communities given availability of an appropriate package of services designed to address multiple needs; 6) have a viable, consistent living environment with parents, legal guardians or caregivers who are able and willing to participate in the MT PRTF Demonstration Waiver project and to maintain the child in the community. Participants must live within the geographic service areas for the Waiver. Additionally, if the cost of anticipated services is above 100 percent of institutional cost, the youth will not be eligible for enrollment in the PRTF Waiver.

Entrance into the Montana PRTF Demonstration Waiver project will be on a first-come, first-served basis for those who meet the criteria for participation. Once a waiting list has been established, youth will be individually evaluted according to PRTF level of care criteria (detailed below); mental, medical and psychological impairment; risk of deterioration without services; risk of institutional placement; need for supervision; need for formal paid services; assessment of informal supports; assessment of relief needed for primary caregiver; and assessment of health and safety issue that place the individual at risk.

The Plan Manager will manage the waitlist, which will be submitted to the Project Director at the Children's Mental Health Bureau/Developmental Services Division of the Department of Public Health and Human Services. On a quarterly basis, the Plan Manager will review waiting lists in the geographic area where the waiver is available and forward the information to the Project Director and the Children's Mental Health Bureau Chief, who will determine when to reallocate unused capacity to areas where additional capacity may be needed. Reallocation will occur following quarterly review of the waiting list information.

Psychiatric Residential Treatment Facility (PRTF) services are provided 24 hours per day, 7 days per week, in an appropriately licensed inpatient facility staffed by a multi-disciplinary team of licensed and credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for a restrictive level of care necessary for the well being and safety of the patient and others. This is the highest level of care for children, other than Acute Inpatient Care.

Children should be referred to this level of care when: interventions in the community fail to meet the child's needs.

Admission criteria for PRTF services, as documented in the Megellan Medicaid Administration(for Clinical Management Guidelines) for Youth Psychiatric Residential Treatment indicate that admission requires that Criterion A, B, and C are met.

Criterion A: Ambulatory care resources available in the community do not meet the treatment needs of the recipient. (42CFR 441.152a-7).

Accessibility:

One of the following two (2) conditions must be documented and present to satisfy this requirement:

1. In lieu of the PRTF Waiver program, a less restrictive level of care will not meet the recipient's treatment needs.
2. Documented factors related to the recipient's family or community prevents effective treatment at a less

restrictive level of care within Montana (the recipient's behaviors persist despite appropriate treatment in a less restrictive level of care).

Treatment Effectiveness:

One of the following two (2) conditions must be documented and present to satisfy this requirement:
1. Therapeutic services provided in a less restrictive setting have been attempted and found ineffective, and in lieu of the PRTF Waiver program, the youth is at riskfor treatment in an inptaitient setting.
2. Child/adolescent has a documented history of multiple admissions to a variety of therapeutic settings and has not progressed sufficiently or has regressed.
(Family or relative placements, community services, therapeutic family care, or therapeutic group home care).

Severity:

The following condition must be documented and present to satisfy this requirement. Assessments conducted by a physician or a qualified mental health professional clinician demonstrates the need for an active provision of multiple therapies in an inpatient setting, and the youth and family are provided the choice to receive services in either a PRTF or in the PRTF Waiver program.

Criterion B:

In lieu of the PRTF Waiver program, ther appropriate treatment of the reciipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152a-2).

Both of the following two conditions must be documented and present to satisfy Criterion B:
1. A covered DSM-IV diagnosis as the principal diagnosis and a determination that the recipient has a serious emotional disturbance (SED).
2. The recipient is currently experiencing severely dysfunctional problems related to the diagnosed psychiatric disorder as demonstrated in one (1) of the following areas:
a. Self Care Deficit: Refusal to comply with treatment, refuses medication, persistent and severely depressed mood, self-care deficit may also place recipient in life threatening situations.
b. Impaired Safety: History of chronic and severe loss of impulse control, repeated aggressive or destructive behavior toward self, others, or property, presence of suicidal ideation, gestures, or attempt or history of in family or peer group.
c. Severely impaired role functioning in the family, school, and/or community.

Criterion C:

The services can reasonably be expected to improve the recipient's condition or prevent further regression so that residential treatment services will no longer be needed (CFR 441.155, 441.156).In lieu of receiving waiver services, the outh would regress and require institutionalization or inpatient hospitalization in the community. All of the following requirements must be documented and present to satisfy Criterion C.

1. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for residential treatment care.
2. The Individualized Treatment Plan (ITP) clearly documents goals and measurable objectives derived from the diagnostic evaluation.
3. The ITP is developed by a team which includes professionals, the youth, and youths parents/legal custodian in whose care the youth may be released after discharge.
4. The ITP clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently in their own environment.
5. The ITP clearly documents a comprehensive Discharge Plan that is based on treatment goals and measurable objectives. The ITP specifies approximate discharge date, post discharge service needs, identified post discharge service providers to insure continuity with the recipient's family, school, and community upon discharge, and any other provisions necessary for transition to a lesser restrictive environment.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

◉ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

○ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. **Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

Megellan Medicaid Administration

- **Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing intial evaluations will be mental health professionals licensed with the State of Montana.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Psychiatric Residential Treatment Facility (PRTF) services are provided 24 hours per day, 7 days per week, in an appropriately licensed inpatient facility staffed by a multi-disciplinary team of licensed and credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for a restrictive level of care necessary for the well being and safety of the patient and others. This is the highest level of care for youth, other than Acute Inpatient Care.

Youth should be referred to this level of care when: (a) interventions at the community level of care have failed to meet the youth's needs in the community setting;

PRTF services should be prepared to meet a youth's psychosocial needs, including educational goals. If a youth has an Individualized Education Plan (IEP) upon admission to the facility, then that facility must follow the educational plan as outlined in the IEP. If a youth does not have an IEP upon admission and the youth's educational plan is compromised due to emotional or behavioral issues, it is expected that a written referral to the home school district be made prior to the youth's discharge from the facility in order to facilitate access to services upon the youth's return to the home community.

PRTF level of care is considered as short term medical treatment (approximately 120 days) with therapeutic interventions developed to stabilize the recipient's emotional and behavioral disturbance and then stepped down to a less restrictive level of care. For purposes of the PRTF Waiver, Level of Care reevaluations will be conducted at 12 month intervals.

The Clinical Management Guidelines for Youth Residential Treatment, including admission, continued stay, and discharge criteria are as follows:

Admission Criterion: (Admission requires Criterion A, B, and C is met)

Criterion A: Ambulatory care resources available in the community do not meet the treatment needs of the recipient. (42CFR 441.152a-7).

Accessibility:
One of the following two (2) conditions must be documented and present to satisfy this requirement:
1. In lieu of the PRTF Waiver program, a less restrictive level of care will not meet the recipient's treatment needs
2. Documented factors related to the recipient's family or community prevents effective treatment at a less restrictive level of care within Montana (the recipient's behaviors and/or symptoms persist despite appropriate treatment in a less restrictive level of care).

Treatment Effectiveness:

One of the following two (2) conditions must be documented and present to satisfy this requirement:
1. Therapeutic services provided in a less restrictive setting have been attempted and found ineffective, and in lieu of the PRTF Waiver program, the youth is at risk for treatment in inpatient setting.
2. Child/adolescent has a documented history of multiple admissions to a variety of therapeutic settings and has not progressed sufficiently or has regressed (e.g., family or relative placements,Community services, therapeutic family care, or therapeutic group home care).

Severity:

The following condition must be documented and present to satisfy this requirement: Assessments conducted by a physician or a qualified mental health professional clinician demonstrates the need for an active provision of multiple therapies in an inpatient setting, and the youth and family are provided the choice to receive services in either a PRTF or in the PRTF Waiver program.

Criterion B:
In lieu of the PRTF Waiver progrm the appropriate treatment of the recipient' psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152a-2).

Both of the following two conditions must be documented and present to satisfy Criterion B:
1. A covered DSM-IV diagnosis as the principal diagnosis and a determination that the recipient has a serious emotional disturbance (SED).
2. The recipient is currently experiencing severely dysfunctional problems related to the diagnosed psychiatric disorder as demonstrated in one (1) of the following areas:
a. Self Care Deficit
(Refusal to comply with treatment, refuses medication, persistent and severely depressed mood, self-care deficit may also place recipient in life threatening situations.)
b. Impaired Safety
(History of chronic and severe loss of impulse control, repeated aggressive or destructive behavior toward self, others, or property, presence of suicidal ideation, gestures, or attempt or history of in family or peer group.)
c. Severely impaired role functioning in the family, school, and/or community.

Criterion C:
The services can reasonably be expected to improve the recipient's condition or prevent further regression so that residential treatment services will no longer be needed (CFR 441.155, 441.156).In lieu of receiving waiver servcies, the youth would regress and require institutionalization or inpatient hospitalization in the community.

All of the following requirements must be documented and present to satisfy Criterion C:
1. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for residential treatment care.
2. The Individualized Treatment Plan (ITP) clearly documents goals and measurable objectives derived from the diagnostic evaluation.
3. The ITP is developed by a team which includes professionals, the youth and the youth's parents/legal custodian in whose care the youth may be released after discharge.
4. The ITP clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently in their own environment.
5. The ITP clearly documents a comprehensive Discharge Plan that is based on treatment goals and measurable objectives. The ITP specifies approximate discharge date, post discharge service needs, identified post discharge service providers to insure continuity with the recipient's family, school, and community upon discharge, and any

other provisions necessary for transition to a lesser restrictive environment.

Patients are seen and evaluated by a physician who documents, consistent with the standards of accrediting and/or licensing agencies, the patient's clinical history, results of the professional's examination, and the ongoing medical and therapeutic progress through discharge. The Individualized Treatment Plan must include individual and group psychotherapy, active involvement, when appropriate, by family members, and all active pre-admission caregivers. The course of treatment and the patient's response to the treatment efforts must be thoroughly documented in records consistent with the standards of accrediting and/or licensing agencies, with daily assessments reflecting progress toward discharge of the patient to a less restrictive level of care. Records must reflect the initiation of discharge planning at the time of admission.

Continued Stay Criterion
All of the following requirements must be documented and present for continued stay:
1. The recipient continues to meet all Admission Criterions.
2. The treatment has stabilized the recipient's behavioral health condition present at admission.
3. In lieu of waiver services the youth would regress and require institutionalization or in patient hospitalization in the community.
4. The facility, the family/guardian, and the community case manager are continuing to identify and document an appropriate less restrictive step down of care.
5. The Treatment Team provides additional clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.

Discharge Criterion:
1. The Individualized Treatment Plan goals and objectives have been sufficiently met that the recipient no longer requires this level of care. OR
2. The recipient voluntarily leaves the program or the recipient's family/guardian removes them from the program.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Megellan Medicaid Administration completes a review to determine that the individual meets level of care requirements for enrollment for PRTF. Pre-admission determination involves reviewing Serious Emotionally Disturbed Criteria (SED); Certificate of Need (CON) and clinical information received from community providers based on established protocols for a PRTF level of care. These are the current instruments used in determining institutional level of care under the State Plan.

The level of care review is performed to evaluate the medical, psychological, and social needs of an individual. The reevaluation process is the same.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**
  Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The Plan Managers will utilize an internal system to track participants enrolled in the Waiver and alert Megellan Medicaid Administration one month prior to the 12-month reevaluation of level of care. The quality assurance process will include a review by the Plan Manager to ensure the timeliness of reevaluation in accordance with quality assurance standards.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and reevaluations of level of care are maintained at Megellan Medicaid Administration the State's contractor, for at least three years as required by 42 CFR §441.303(c)(3). Megellan Medicaid Administration typically makes it a practice to maintain these records for a period of seven (7) years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Megellan Medicaid Administration will complete a PRTF Level of Care within two days of receiving the referral. The numerator is the number of youth who received LOC determination within two working days. The denominator is the number of youth who were referred for LOC determination.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Management reports from Megellan Medicaid Administration sent to the state quarterly will be validated against the Plan Manager's file.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Plan Manager is responsible for ensuring the contractor is notified to complete the level of care reevaluation within 12 months of the initial level of care evaluation. The numerator is the number of required redeterminations that are completed within twelve months of the initial evaluation. The denominator is the number of all required redetermination that were due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Plan Manager will establish a data base with the original level of care evaluation date. This data base will be the trigger for the reevaluation of enrollees.

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified**

		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The contractor, Megellan Medicaid Administration, completes level of care evaluations for youth entering the PRTF Waiver. The process and instruments

are defined in the waiver. The numerator is the number of waiver referrals in which the evaluation is administered in compliance with applicable standards. The denominator is the sum of all referrals in which the evaluation is administered.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records review on site and off site.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State will review quarterly reports from Megellan Medicaid Administration to ensure compliance with stipulated time frames. The State and Megellan will meet to discuss any any of deficiency and outline a corrective action plan mutually agreed upon. The State will require of Megellan a monthly report outlining their compliance with the corrective action plan.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Prior to the level of care determination, the Plan Manager will First inform potentially eligible youth of the feasible alternatives available under the Waiver and allow individuals to choose either institutional or waiver services, as long as the individuals reside in areas where the Waiver is available (the PRTF Waiver will not be available

statewide) and where there is capacity. The Screening Determination form documenting choice will be maintained on file.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Plan Manager will maintain the Screening Determination form, including all documentation regarding freedom of choice, for a minimum of six years and three months.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The State will make reasonable accommodation upon request. Accommodations for foreign translators will be arranged through the local college and university system. Accommodations for individuals who are deaf or hearing impaired will be made through Montana Communications Access Program for the Deaf and Hard of Hearing Services. The State will utilize other resources including, but not limited to, the Special Needs Center through the Qwest phone book. Individuals are notified of the opportunity for reasonable accommodations in the Medicaid application process and in the Medicaid Screening determination letter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Respite Care		
Other Service	Caregiver Peer-to-Peer Support		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Customized Goods and Services		
Other Service	Education and Support Services		
Other Service	Family Support Specialist		
Other Service	Home-based Therapist		
Other Service	Non-emergency Transportation		
Other Service	Wraparound Facilitator		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
Respite Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite care includes services designed to give a hiatus to the primary caregiver while meeting the safety and daily care needs of the youth. This service is designed to help meet the needs of the youth's caregiver and to reduce the stress generated by the provision of constant care to the individual receiving waiver services. Respite providers are selected in collaboration with the parents. Services are provided by persons (ie: agency staff, neighbors or friends),employed and trained by an agency that provides respite care. Respite services are delivered as documented in the individualized plan of care. Respite services can be offered in the youth's home, out of home, or in a licensed facility ie, youth shelter or group home. Respite may not be provided in a psychiatric residential treatment facility (PRTF), or in a school setting.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits are described in the individual Plan of Care.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Therapeutic Group Home
Agency	Youth Shelter
Agency	Group Home
Agency	Any provider with the necessary fiduciary and managerial capacity enrolled as a Montana Medicaid Waiver service provider (e.g., 501(c)(3), licensed mental health center, Kids Management Authority).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Therapeutic Group Home
Provider Qualifications
License *(specify):*
Licensed in the State of Montana
Certificate *(specify):*
NA
Other Standard *(specify):*
Provider must be an enrolled Montana Medicaid provider
Verification of Provider Qualifications
Entity Responsible for Verification:

Department of PublicHealth and Human Services
Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Youth Shelter
Provider Qualifications
License *(specify):*
Liscensed in the State of Montana
Certificate *(specify):*
NA
Other Standard *(specify):*
Provider must be and enrolled Medicaid provider in the State of Montana
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services
Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Group Home
Provider Qualifications
License *(specify):*
Liscensed in the state of Montana
Certificate *(specify):*
NA
Other Standard *(specify):*
Provider must be an enrolled Medicaid provider in the state of Montana
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Human Services
Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency

Provider Type:
Any provider with the necessary fiduciary and managerial capacity enrolled as a Montana Medicaid Waiver service provider (e.g., 501(c)(3), licensed mental health center, Kids Management Authority).

Provider Qualifications

License *(specify):*
Not applicable

Certificate *(specify):*
Not applicable

Other Standard *(specify):*
Must have adequate fiduciary capacity as evidenced by clear audits. The agency is responsible to hire qualified staff and follow all state and federal laws.

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS will enroll the provider, which will then be sent to the Children's Mental Health Bureau. Developmental Services Division staff will authorize each enrollment application and verify fiduciary capacity.

Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Caregiver Peer-to-Peer Support

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Caregiver peer- to peer-support services are designed to offer and promote support to the parent/guardian of the youth with serious emotional disturbance. The services are geared toward promoting self empowerment of the parent, enhancing community living skills,and developing natural supports. These services are intended to assist the parent/guardian in being able to access appropriate formal and informal services for the youth in the community once discharged from the program.
Caregiver Peer-to-Peer Support Services may include:
- assists them in successfully engaging with the wraparound process and staff
- uses their personal and professional life experiences to assist with problem solving, consultation and training for staff to increase their awareness of the difficulties raising a youth with SED thus improving effective parent involvement.
- serves, when requested, as parent representative at school and other treatment meetings

- assists with the development of parent support groups
- assist parents in the development of their own advocacy skills
- consults with parents in making appropriate decisions about the youths activities and services offered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits are described in the individual plan of care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency with the capacity to provide caregiver peer-to-peer support services (with a designated staff to provide supervision of the peer-to-peer support specialist.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver Peer-to-Peer Support

Provider Category:
Agency

Provider Type:
Any agency with the capacity to provide caregiver peer-to-peer support services (with a designated staff to provide supervision of the peer-to-peer support specialist.

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The Caregiver Peer-to-Peer support specialist is an individual who has been a family member of a youth with SED and participated in the youth's day-to-day care. The youth is currently not enrolled in the PRTF Waiver. The Caregiver Peer-to-peer support specialist must be knowledgeable about the children's mental health system as well as about other community resources.

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS is responsible for provider enrollment. Children's Mental Health Bureau is responsible for verification of qualifications.

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultative Clinical and Therapeutic Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consultative Clinical and Therapeutic Services will assist the youth's physician or mid level practitioner in developing and carrying out individual treatment/support plans by providing consultations with psychiatrists. This service is specifically designed to provide treating physicians and mid level practitioners with psychiatric expertise and opportunity for consultation in the areas of diagnosis, treatment, behavior and medication management.

Consultative Clinical and Therapeutic Services will be provided by licensed psychiatrists enrolled with the State of Montana as Medicaid providers. Consultation will be provided to a physician or Mid Level Practitioner for a youth enrolled in the PRTF waiver program.

A list of psychiatrists participating in the Waiver will be maintained by the plan managers in each county served by the demonstration project. If counties who provide services for the demonstration project do not have the availability of a psychiatrist, a physician can consult with a psychiatrist in another county. Both the consulting psychiatrist and the requesting physician may bill for the consult.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The individual limit for this service will be described in the individual plan of care.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychiatrist
Individual	Physician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Individual

Provider Type:
Psychiatrist

Provider Qualifications

License *(specify):*
Physicians who practice psychiatry must be board certified or board eligible and licensed by the State of Montana (or in the state where they maintain their practice) and must be enrolled as a psychiatrist with Montana Medicaid.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS, the Department's fiscal agent, is the contract agency that is responslble for verifying licensure upon enrollment of providers.

Frequency of Verification:
Upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:
Individual

Provider Type:
Physician

Provider Qualifications

License *(specify):*
Physicians must be board certified or board eligible and licensed by the State of Montana (or in the state where they maintain their practice) and must be enrolled as a physician with Montana Medicaid.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS, the Department's fiscal agent, is the contract agency that is responslble for verifying licensure upon enrollment of providers.

Frequency of Verification:

Upon enrollment and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Customized Goods and Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Customized Goods and Services will be available to purchase services/goods not provided by Medicaid. The Customized Goods and Services funds will be utilized for access to supports designed to improve and maintain the youth's opportunities for full membership in the community, socialization and enrichment, as specified by the individual Plan of Care. Use of the Specialized Goods and Services Funds must be related to one or more of the following outcomes: success in school; maintaining the youth in the home; development and maintenance of healthy relationships; prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or becoming or remaining a stable and productive member of the community. Services will help youth alleviate some of the stressors in their living situations, and help them cope with day to day living. Customized Goods and Services funding may NOT be used to provide any otherwise covered services or goods, including (but not limited to) monthly rent or mortgage, food, regular utility charges, household appliances, or items that are for purely diversional/recreational (e.g., televisions or stereos). The Plan Manager and family must attempt to identify alternative funding/resources prior to the approval of Customized Goods and Services funds.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Customized Goods and Services funding will not exceed $1000.00 per family per waiver year (enrollment date begins waiver year). This funding will not be used to purchase goods and services that are available through another funding source ie: school systems, IDEA, etc. The use and need for these funds will be described in the individual plan of care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any provider with the fiduciary capacity and is enrolled as a Montana Medicaid provider of Waiver services (e.g., 501(c)(3)s, licensed mental health centers, Kids Management Authorities).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Customized Goods and Services

Provider Category:
Agency

Provider Type:
Any provider with the fiduciary capacity and is enrolled as a Montana Medicaid provider of Waiver services (e.g., 501(c)(3)s, licensed mental health centers, Kids Management Authorities).

Provider Qualifications

License *(specify):*
Not applicable

Certificate *(specify):*
Not applicable.

Other Standard *(specify):*
Must have appropriate fiduciary capacity as demonstrated by clear audits.

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS will enroll the provider, which will then be sent to the Children's Mental Health Bureau. Developmental Services Division staff will authorize each enrollment application and verify fiduciary capacity.

Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Education and Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Education and support will be provided for unpaid caregivers and treatment team members (e.g., immediate and extended family, teachers, aides). Instruction on the diagnostic characteristics and treatment regimens (including medication and behavioral management) for the youth will be provided in a group setting. The Education and Support Services have been designed to provide support for families parenting youth with severe emotional disturbance through skill-building in coping skills, dealing with schools, and advocacy.

Education and support services are provided by appropriate community agencies with the capacity to offer periodic trainings specific to parent(s) or legal guardians of youth with serious emotional disturbance. All training curricula and community providers of such training must be approved by the department. The provider will provide materials, space and hand-outs for the sessions.

The curriculum will be flexible enough that it can be tailored to families requesting information particular to the mental health issues of the youth. Classes will be offered at convenient times and location for parent participation.

Education and Support Services may be provided to non-Waiver participants, but payment for this waiver service can only be billed for participants specifically and directly affiliated with a PRTF Waiver participant up to a total of 7 persons per youth. Funding for this service is not already available through other programs such as; IDEA,Rehab Services Act of 1973, or the Schools.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits for service will be described in the individual plan of care. Up to 7 members of a youth's team (including family, service providers and others) can opt to participate in the training.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency with the capacity to provide trainings specific to the needs of families of youth with Serious Emotional Disturbance with curriculum approved by the Department.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Education and Support Services

Provider Category:
Agency

Provider Type:
Any agency with the capacity to provide trainings specific to the needs of families of youth with Serious Emotional Disturbance with curriculum approved by the Department.

Provider Qualifications

License *(specify)*:
Not applicable.

Certificate *(specify)*:

Other Standard *(specify)*:

Trainings may be provided by agencies or individuals whose curriculum has been approved by the Department and who is a HCBS enrolled provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

ACS will refer potential HCBS providers of Education and Support Services to the Department for approval or disapproval of the enrollment application. At this time the Department will contact the potential HCBS providers for approval of curriculum.

Frequency of Verification:

Upon enrollment and if their curriculum is amended.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Support Specialist

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Family Support Specialist, under the guidance of the home-based therapist, will provide support and interventions to parents and youth. Other tasks may include:

- assisting the therapist in family therapy by helping the parent/child communicate their concerns
- provides feedback to the therapist about observable family dynamics
- helps the family and youth implement changes discussed in family therapy and/or parenting classes
- may provide education to the parent regarding their child's mental illness
- Can coach, support, and encourage new parenting techniques
- can help parents learn new parenting skills specific to meet the needs of their child
- participates in family activities and supports parents in applying specific and on the spot parenting methods in order to change family dynamics.
- Member of crisis intervention team.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits of this service are determined by the individual plan of care. This service will not duplicate any other service available to the participant.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency with the capacity to provide family support specialist services .

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Support Specialist

Provider Category:
Agency

Provider Type:
Agency with the capacity to provide family support specialist services .

Provider Qualifications

License *(specify)*:
The agency must ensure the family support specialist has a Bachelor's degree in the Human Service field OR three years direct experience (as documented by the agency) working with youth with SED and their families. The agency must ensure that the family support specialist receives clinical supervison.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
ACS is responsible for enrollment and Children's Mental Health Bureau is responsible for verfication of qualifications.

Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home-based Therapist

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope):*
Home-based therapists are licensed mental health professionals who provide face-to-face, individual and family therapy for youth/family in the family home at times convenient for the family and youth. The therapist will guide: the transition process to the PRTF Waiver; the engagement, planning, creation of the crisis plan; and transition from the Waiver services.
The Home-based therapist and the wraparound facilitator cannot be employed by the same agency.

The home-based therapist:
- Assesses, recommends and makes updates to the treatment plan;
- Communicates with the Plan Manager regarding to eligibility status, services and treatment;
- Develops and writes individual treatment plan with the family;
- Reassesses, amends, and updates the individual treatment plan;
- Is available to provide crisis response during and after working hours;
- Guides the crisis plan development and monitors implementation;
- Guides transition of the youth to the community from a PRTF Waiver;
- Guides the engagement process by exploring and assessing the strengths and needs of the youth and family;
- Attends family and team meetings;
- Guides the planning process by informing the team of the family vision;

There are two separate units that can be billed for home based therapist services; direct service billing at 15 minute increments and billing for attendance at treatment team meetings per diem rate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits for this service are determined in the individual Plan of Care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Mental Health Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-based Therapist

Provider Category:
Individual

Provider Type:
Licensed Mental Health Professional

Provider Qualifications

License *(specify):*
The Home-based Therapist will be a licensed mental health professional in the State of Montana. Licensed mental health professionals include; Licensed Certified Professional Counselors (LCPC), Licensed Clinical Social Workers (LCSW),and Licensed Clinical Psychologists.

Certificate *(specify):*

Not applicable.
Other Standard *(specify):*
Not applicable.
Verification of Provider Qualifications
Entity Responsible for Verification:
ACS, the Department's fiscal agent, is the contract agency that is responsible for verifying licensure upon enrollment of providers.
Frequency of Verification:
Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-emergency Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Non-emergency Transportation means non-medical transportation and enables participants to gain access to Waiver and other community services, supports, activities and resources specified by the individual service plan. Transportation may be provided for such activities as treatment team meetings, social, recreational and spiritual activities. All non-emergency transportation must be specifically included in the treatment plan and pre approved by the Plan Manager. Participants will be encouraged to access transportation through other sources, and to use non-medical transportation only as a last resort. Non-medical transportation may not be used to transport an individual to school, or for transportation services that are currently provided under the state plan.

Non-emergency Transportation is limited to meeting the individual youth's needs, as specified in the individual plan of care. Non- emergency transporters will be employees of the agencies who provide this service. Agencies providing Non-emergency Transportation services must ensure that drivers have appropriate qualifications and valid Montana drivers licenses.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits are described in the individual Plan of Care.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any provider with the necessary fiduciary and managerial capacity enrolled as a Montana Medicaid Waiver service provider (e.g., 501(c)(3), licensed mental health center, Kids Management Authority).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-emergency Transportation

Provider Category:

Agency

Provider Type:

Any provider with the necessary fiduciary and managerial capacity enrolled as a Montana Medicaid Waiver service provider (e.g., 501(c)(3), licensed mental health center, Kids Management Authority).

Provider Qualifications

License *(specify):*

The provider must ensure that transporters provide proof of a valid Montana driver's license; adequate automobile insurance; and assurances that the vehicle is in compliance with all applicable federal, state and local laws and regulations.

Certificate *(specify):*

Not applicable

Other Standard *(specify):*

Must have adequate fiduciary capacity as evidenced by clear audits.

Verification of Provider Qualifications

Entity Responsible for Verification:

ACS will enroll the provider, which will then be sent to the Children's Mental Health Bureau. Developmental Services Division staff will authorize each enrollment application and verify fiduciary capacity.

Frequency of Verification:

Upon enrollment.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Wraparound Facilitator

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process.
Assembles the Wraparound Team
Conducts Plan of Care Meetings
Along with the Wraparound Team, helps identify needs of youth and family
Works with the Plan Manager in identifying providers of services and other community resources to meet family and youth needs and makes necessary referrals.
Responsible for the documentation and maintenance of all documentation regarding the Plan of Care and the Cost Plan and all revisions to the Plan of Care and/or Cost Plan developed by the Wraparound Team
Presents Plan of Care and Cost Plan to Plan Manager for approval.
Monitors the implementation of Plan of Care, making sure family and youth are receiving the services identified in Plan of Care.
Maintains communication between all team members
Consults with family and other team members to make sure the services the youth and family are receiving continue to meet their needs and assembles the team to make necessary adjustments and revisions.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limits are described in the Individual Plan of Care. A wraparound facilitator, who is a licensed mental health professional, cannot provide any other direct care waiver or state plan services for the youth they are facilitating. The agency providing wraparound facilitation must provide freedom of choice for all other waiver and state plan service they provide. The Wraparound Facilitator and the In-Home Therapist cannot be employed by the same agency. This service will not duplicate any other servcies provided to the participant.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Any provider who is either a licensed mental health professional or an individual employed by an agency who are enrolled Montana Medicaid Providers.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Wraparound Facilitator

Provider Category:
Individual

Provider Type:
Any provider who is either a licensed mental health professional or an individual employed by an agency who are enrolled Montana Medicaid Providers.

Provider Qualifications
License *(specify)*:

The wraparound facilitator will be a licensed mental health professional in the State of Montana. Licensed mental health professionals include; Licensed Certified Professional Counselors (LCPC), Licensed Clinical Social Workers (LCSW), and Licensed Clinical Psychologists.

Certificate *(specify):*

Certified or working toward wraparound certification.(individual providing wraparound facilitation must have attended a state sanctioned wraparound training or has been trained by an individual in the agency they work for who has attended a state sanctioned wraparound training. This individual must attend the next available state sanctioned training).

Other Standard *(specify):*

An agency employing a wraparound facilitator must enroll as a Montana Medicaid HCBS provider and ensure that the wraparound facilitator is working under the supervision of a license mental health professional.

The wraparound facilitator employed by an agency, who has completed the Wraparound 101 Training sanctioned by CMHB may train an individual hired by the agency to do wraparound facilitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

ACS , the Department's fiscal agent, is responsible for verifying credentials upon enrollment of providers.

The State Wraparound Coordinator is responsible for verifying that the individual completed wraparound facilitation training and are working toward certification.

Frequency of Verification:

Upon enrollment.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Plan Manager is an employee of the Department of Public, Developmental Services Divison/Children's Mental Health Bureau. S/he will provide all core functions of a case manager until Wraparound Facilitation services begin. The Plan Manager may be a Wraparound Facilitator, then making it a waiver service as defined in C-3. The Plan Manager will be responsible to;

-Initial Point of contact for all referrals to PRTF Waiver
-Assess referral packet for eligibility to PRTF Waiver
-Gather's additional information regarding services that have been received
-If child appears to meet the criteria for PRTF Waiver, Plan Manager will meet with the family and youth to discuss the PRTF Waiver the Wraparound Service Delivery Model
-If family chooses the PRTF Waiver, Plan Manager will send referral information to Megellan for Level of Care determination. (Youth and Family signs Freedom of Choice Form).
-If youth meets Level of Care, Plan Manager will meet again with family to begin identifying family and youth

strengths, needs, and will offer a choice of service providers including the Wraparound Facilitator
-Complete all eligibility forms, consent forms and distribute and collect the Child Behavior Check List (CBCL) evaluation forms
-If the Plan Manager is not the Wraparound Facilitator the Plan Manager will refer youth and family to the Wraparound Facilitator, chosen by the family,
-Involved in the development of the initial Plan of Care and Cost Plan with the wraparound team.
-Plan Manager will send Cost Plan to Project Director for approval.
-Monitor ongoing eligibility status
-Receives and maintains documentation of Plan of Care and all adjustments and/or revisions to the Plan of Care.
-The Plan manager will review any adjustments to the Cost Plan and will send to Project Director for approval.
Participate in periodic wraparound meetings in order to monitor fidelity of the wraparound process and as invited by the wraparound team.
-Collect and submit required Minimal Data Set (MDS) to Federal Contractor
-Monitor aggregate local cost of Waiver and Medicaid services on a monthly basis
-Networks with community resources
-Will provide quality management over-site to all wraparound teams within their region.
-Is a resource to the wraparound facilitator
-Will be a resource, including training as necessary, for all waiver providers
-Will maintain waiting list to PRTF program, in accordance to approved wiaver guidelines

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- (●) **No. Criminal history and/or background investigations are not required.**
- ( ) **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (●) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All potential PRTF Waiver providers may become Medicaid providers as long as they meet the provider qualifications and are capable of providing services in areas of the state where the PRTF Waiver is available. Providers meeting all provider requirements are encouraged to enroll as Medicaid providers. All requests for enrollment in the Medicaid Program must be made through the State's fiscal intermediary, Affiliated Computer Systems (ACS). ACS will provide interested providers with enrollment information. There is a continuous, open enrollment of Waiver service providers. Additionally, the State has established an on-line process for potential providers to access information electronically. The on-line process allows potential providers to access the provider application as well as applicable provider manuals for specific services at any time. The web sites for this electronic process are:
http://medicaidprovider.hhs.mt.gov/enrollmenttutorial/CONTENTS.html; and
https://mtaccesstohealth.acs-shc.com/mt/general/providerEnrollmentHome.do

The enrollment application must be completed in its entirety before ACS is able to process the enrollment application. This is the same process for the enrollment of any Montana Medicaid provider. As specified in the contract between the Department and ACS, ACS has ten working days to issue a provider number. ACS will forward all completed enrollment applications to the Children's Mental Health Bureau (CMHB) Developmental Services Division (DSD), Department of Public Health and Human Services, for approval, procedure codes and rates. The DSR will act upon the completed enrollment application within five working days of receipt and return it to ACS for action.

The Plan Manager will be responsible for Waiver provider outreach to ensure there is an adequate listing of willing, available and qualified waiver providers from which the youth and family may choose. There is information on the Department's web-site to assist potential providers who are seeking information about Montana Medicaid and programs.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**
   i. **Sub-Assurances:**

      a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

         Performance Measures

         For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

         For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Department of Public Health and Human Services monitors the qualified provider standards for all PRTF waiver funded services, by individually approving their enrollment application. The numerator is the number of enrolled providers who are qualified and the denominator is the number of providers who submitted enrollment applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment applications submitted to the state from ACS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ACS, the departments fiscal agent	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Upon submitted application for enrollment as a PRTF waiver provider.

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The DPHHS monitors the qualified provider standards for all PRTF waiver funded services, by approving their enrollment application. The numerator is the number of enrolled providers who are qualified and the denominator is the number of providers who submitted enrollment applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment applications submitted to the state from ACS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ACS the departments fiscal agent.	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Upon submitted PRTF waiver provider applicaiton.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The Department of Public Health and Human Services implements new policies, administrative directives and rules associated with ongoing training and competency requirements for staff providing waiver services. The numerator is the number of providers in compliance with ongoing training requirements. The denominator is the number of providers enrolled in the PRTF Waiver.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department does not do Criminal Background checks except for state staff who are participating in the PRTF Waiver. ACS, our fiscal agent, with each individual enrollment goes through a proceedure of checking with licensing entities within the Department of Labor and Industries, the Excluded Indivdiual and Entities List,and Medicare exclusion lists. The hard copy of the Licensee Lookup System indicates any adverse action or information regarding the enrollee and may prevent that individual from being enrolled as a PRTF Waiver Provider. All contracts issued by the Department goe through a review process to insure the potential contractor is not on the Federal Debarment List.

The Department has establish qualifications for state staff, including criminal background checks, who are participating in the PRTF Waiver. Minimum qualifications for the Plan Manager include a Bachelor's degree in the Human Service Field and at least three years experience in the Children's Mental Health system. The Project Director must have at least a Bachelor's degree in the human service field however, a Master's degree is preferred and experience in supervision and at least three years experience in the Children's Mental Health System. The minimum qualification for the PRTF Waiver Fiscal Analyst include a Bachelor's degree in business, finance, accounting, health administration and/or public administration and two years of work related experience.
These positions will be hired through the State's rigorous hiring process, which includes screening for minimum qualifications, an extensive application form, and, an interview with the hiring committee and a Criminal Background Check.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Plan Manager and the Project Director will conduct internal audits of enrolled PRTF Waiver providers to ensure their compliance with qualification standards. If it is discovered that a provider is not in compliance with the qualification standards the provider will be issued a letter stipulating a corrective action plan. Their provider number will be inactivated until the provider demonstrates compliance.
Staff who do not adequately perform the duties assigned to them in their roles with the PRTF Waiver program will be subject to the Department's progressive discipline process and, if quality of performance does not improve,will be replaced.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party *(check each that applies)*:	Frequency of data aggregation and analysis *(check each that applies)*:
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐ **Licensed physician (M.D. or D.O)**
☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker.**
Specify qualifications:

☑ **Other**
Specify the individuals and their qualifications:

Wraparound Facilitator(who assumes case management functions upon enrollment of youth into program). See Appendix C-1/C-3 Provider Specifications for Service.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

A licensed mental health professional may not provide any other waiver or state plan services for the individual they are providing wraparound facilitation for. An agency providing wraparound facilitation must provide freedom of choice for all other waiver and state plan services they provide. An agency providing wraparound facilitation may not provide Home-based therapy for the same youth.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Youth with SED and their parents/legal guardians will develop the plan of care with the Wraparound Facilitator, the Home-based Therapist, and others named by the parents/legal guardians who are involved with support, therapeutic intervention and/or other services for the youth. The youth and his/her parents/legal guardians have the authority to determine who is included in the process of Plan of Care development. The parent/legal guardian chooses the members to be included to develop the plan of care. These can include such persons as family members, friends or other supportive persons from the community. This specifically selected group of people will be designated as the Wraparound Team.

The Wraparound Facilitator will maximize the extent to which the youth and his/her parent/legal guardian participates by engaging them in the wraparound planning process. They will assist the youth in their exploration and identification of preferences, desired outcomes and goals. The services and supports selected from a broad menu will be designed to assist the youth in achieving the articulated outcomes desired. They also will assist the youth with identifying and reviewing issues that need to be taken into consideration during the planning process and will give each youth/parent or legal guardian the opportunity to determine the location and time of planning meetings, the participants attending the meetings, and the frequency and length of the meetings. The youth/parent or legal guardian signs off on the Plan of Care once it has been completed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Service Plan Development Process

Prior to the development of the Service Plan, the Plan Manager will meet with the youth and family to explain the PRTF Waiver program, services available under the program and will offer choice of involvement in the program. The Plan Manager will engage the youth and family in identifying strengths, needs and individuals to be included as part of the Wraparound Team. Either the Plan Manager will be the wraparound facilitator for the family or the family will be provided the opportunity to chose a Wraparound Facilitator from a list of providers maintained

by the Plan Manager. If the Plan Manager is not the wraparound facilitator the Plan Manager will refer the youth and family to the Wraparound Facilitator who will then arrange the team meeting to begin the development of the Plan of Care. After the initial Plan of Care meeting to develop the Service Plan, if the the Plan Manager is not the Wraparound Facilitator the Plan Manager will only be involved in program oversite and will remain a resource to the Wraparound Facilitator and youth and family.

(a) who develops the plan, who participates in the process, and the timing of the plan;

The youth with SED and his/her parent/legal guardian will work with the Wraparound Facilitator, the Home-based Therapist and any others selected by the youth/parent for the Wraparound Team to develop the plan of care, as described in the response to D-1-c. The Plan of Care is the written plan developed by this team, and is based on the needs and status of the Youth. Once developed, the youth and legal guardian must sign the Plan of Care, which is then approved by the Project Director.

Timing of the plan: The Plan Manager will notify Megellan Medicaid Administration whenever a Medicaid youth is being considered for admission to the PRTF Waiver Program for prior approval and verification of medical necessity. The Plan Manager will verify Medicaid eligibility. The enrollment date is the date the youth is determined to meet level of care by Megellan. This date will be entered on the Plan of Care form and documented in the client case notes.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status;

Types of assessments: The Plan Manager will distribute the Child Behavior Check List (CBCL) to the youth, caregiver, therapist, and school personnel when the youth is enrolled in the PRTF Waiver. The CBCL will be administered at enrollment, every six months and upon discharge from the PRTF Waiver

Securing information about participant needs, preferences, goals and health status: The Plan Manager will compile information that documents the status and needs of the youth. Part of this process entails reviewing information available from the referring source, including but not limited to psychiatric diagnostic assessments, psychological assessments, complete social history information from previous out-of-home placements, previous therapists, school records, information from child protective services, juvenile justice, and the department of corrections. As needed, and with the legal guardian's approval, the Plan Manager may also consult with other health care professionals, family members, relatives, psychologists, and others.

The assessment described above will be used to determine strengths, capacities, risk factors and needs, as well as the youth's physical and mental health status. When all of the information has been obtained the Plan Manager will meet with the Wraparound Facilitator, chosen by the youth and family, to begin the Wraparound Process. Additionally, the Wraparound Facilitator will work closely with the youth and his/her caretaker to ascertain their needs and preferences are met, as well as to establish goals.

(c) how the participant is informed of the services that are available under the waiver;

The Plan Manager informs the youth and his/her caretaker about the services available to them under the Waiver, the Wraparound Facilitator will provide clarification and additional information throughout the process of developing the Plan of Care.

Developing the Plan of Care includes providing the youth with a choice of providers. The Plan Manager will maintain a list of Waiver service providers in the geographic areas of the state where the PRTF Waiver is available and will make this list available to the Wraparound Facilitator. (This list is likely to vary by geographic area.) Signatures by the youth and legal guardian on the plan of care acknowledge freedom of choice of waiver providers.

(d) how the plan development process ensures that the plan of care addresses participant goals, needs (including health care needs), and preferences;

The plan development process is youth centered, which ensures that the service plan addresses the articulated needs, goals and preferences of the Youth. The Wraparound Facilitator, Home-based Therapist, and any others selected by the youth/parent for the wraparound team assist in the development of the plan, which ensures that professionals are examining the needs of the youth therapeutically, and in context with the services available under the Waiver and in the community. Each completed and approved Plan of Care must include the following components, which are also

designed to ensure that the participants' goals and needs are met.

Individualized Plans of Care draw from a menu of the services and supports (e.g., respite, nonemergency transportation, customized goods and services). Every Waiver service available will not be needed by every Youth, however all regular State Plan Medicaid services and PRTF Waiver services may be available to demonstration project youth. Each service and support package will be based on individual need.

(e) how waiver and other services are coordinated;

In addition to the components specified below, the Plan of Care will list non-waiver services to be used by participants. The Wraparound Facilitator will make all necessary referrals for non-waiver services for participants.

Each individual Plan of Care shall include at least the following components:
- A current psychological assessment describing diagnosis, symptoms, and verification of medical necessity;
- An individual therapeutic treatment plan for the youth;
- A description of the youth's functional level at home, school and in the community;
- Specific short-term objectives and long-term goals;
- The youth's desired outcomes;
- A description of risk factors specific to the youth;
- Special procedures recommended to ensure the health and safety of the youth;
- Crisis plan with a specific definition of "crisis" that includes the phone numbers of appropriate persons who will respond in crisis, alternative crisis plans and contact information for crisis response;
- A discharge plan;
- Description of the following, as pertinent:
o Medications;
o Treatments, including mental health regime;
o Activities;
o Therapies;
o Involvement with social service, corrections, or juvenile justice systems.

The Plan of Care will also include:
- The specific services to be provided, the frequency of those services and the types of providers for those services;
- A Strength, Needs, Culture Discovery which will summarize the youth and family's strengths and needs in all life domains;
- A cost sheet which projects the annualized costs of PRTF Waiver services; and
- Signatures of those who have participated in developing the Plan of Care (e.g., the youth, legal guardian, the Plan Manager,the Wraparound Facilitator and the Home-based Therapist).

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and,

Implementation: The Wraparound Facilitator is largely responsible for monitoring and ensuring the implementation of the Plan of Care. This will be accomplished by monitoring the services utilized by the youth, and ensuring that they are delivered in the amounts prescribed, and that the appropriate providers have been used. The Plan Manager will ensure fidelity to the Plan of Care by monitoring and pre-approving all Waiver services. The Plan Manager will also provide over site to the Plan or Care to ensure Fidelity to the Wraparound Process.

Monitoring: All Plans of Care are monitored at the onset of services and reviewed by the Department of Public Health and Human Services (DPHHS)annually. These responsibilities are assigned to the Project Director, who will review all portions of the plan utilizing the criteria below.
- Completeness of the plan, including ensuring that all necessary services are listed in terms of amount, frequency and planned provider(s) with assurances that participants have had free choice of providers from a roster of Waiver providers;
- Consistency of the plan with screening information regarding the youth;
- Presence of appropriate signatures; and
- Cost-effectiveness.

The Plan of Care must document costs, including state plan and PRTF Waiver services provided, the frequency, amount and projected annualized cost of those services. The Wraparound Facilitator will prepare the cost sheet after the Plan of Care has been developed. The Plan Manager will review the Plan of Care and the Cost Sheet and submit to the Project Director for final approval. The cost sheet will be completed to determine initial program eligibility. A

new cost sheet must be completed at least annually, or as needed. The Wraparound Facilitator must explain the cost sheet to the youth and family, and document mailing of the form to the family. The Wraparound Facilitator will review the cost sheet with the youth/legal guardian during the three-month Plan of Care review. (This process is outlined to avoid redundency of services provided by the Plan Manager and the Wraparound Facilitator).

(g) how and when the plan is updated, including when the youth's needs change.

Subsequent plans of care must be completed at least annually or as the youth's condition warrants it as reflected by the recommendation of the Home-based Therapist or at the request of the youth/legal guardian. The plan of care is reviewed every three months with the youth/ legal guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Training and information will be provided to each youth/legal guardian that covers health and safety issues relative to the diagnosed SED, crisis planning, risk identification, assessment, and behavior management. The youth and his/her family members will complete the CBCL (Child Behavior Check List) evaluation tool as part of the planning and implementation process. If the youth is not capable of or old enough to fill out the CBCL, then the caretaker will do so for him/her.

The crisis plan, risk identification and management are all components of the individual Plan of Care. Crisis plans will be defined and planned for on an individual basis. The crisis plan will include an assessment of critical services and a strategy for each identified critical service. Depending upon the service array available in a given geographic area the crisis plan could include:
1. Family crisis response incorporated into the plan;
2. Informal crisis response (for example, family, friends, and neighbors);
3. Enrolled Medicaid provider network (for example, crisis response agencies); and
4. System level (local emergency response).

If one of the crisis plan services is an identified waiver service, then it may be paid for by the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The participants will have the opportunity to select from a list of providers prepared by the Plan Manager. All providers included on the list will be eligible to provide Medicaid services and will be enrolled as Medicaid providers. The list provided to the participants will also include only qualified Waiver providers who have the capacity to offer the specific services needed and who are within the geographic areas of the state where the PRTF Waiver is available. The list will vary by geographic area. If the participants are dissatisfied with the list of available agencies, the Plan Manager will solicit other providers for services.

Any provider interested in offering PRTF Waiver services must enroll as a Medicaid provider. Approval is contingent on specific requirements set for each service type, but might include such qualifications as proof of licensure, certification, or registration according to Montana state laws and regulations; a W-9; and agreement to meet all specified conditions regulating the specific provider type, program and/or service. Providers must complete a Montana Medicaid Provider Enrollment Form, which serves as a contract between the provider and the Department. Each provider is assigned a Montana Medicaid provider number for each type of service provided, which are then used in all Medicaid correspondence.

After choosing providers, the participantswill sign a form within the Plan of Care to acknowledge that they have chosen freely from among the available Waiver providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

All Plans of Care are subject to review by the Department of Public Health and Human Services (DPHHS), the Medicaid Agency for the State of Montana. The Developmental Services Division/Children's Mental Health Bureau are housed within the DPHHS, and have been assigned the approval and review functions. These functions will be the responsibility of the PRTF Waiver Project Director.

The Project Director will be charged with regularly reviewing and monitoring all Plans of Care, the planning process, documentation, quality, and delivery of services to PRTF Waiver participants. The Project Director will approve the initial Plan of Care for a Youth enrolled in the PRTF Waiver. On an annual basis, the Project Director, or designee will interview 25% of PRTF Waiver participants in each geographic location to ensure that the youth/legal guardians are directing the development of their Plans of Care, that they have agreed to all services outlined in the Plans of Care, had freedom of choice of service providers and that they signed the plans of care and were provided with copies for their files.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (•) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [ ] **Case manager**
- [x] **Other**

Specify:

The Wraparound Facilitator will also maintain a copy of the Plans of Care.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare;
The Wraparound Facilitator will assume primary responsibility for ensuring that the services detailed in the Plan of Care have been provided, by the designated providers, and in the quantities described by the Plan of Care. Any decompensation in the health and welfare of the youth will be reported to the Wraparound Facilitator, who will then report it to the Plan Manager, by the Home-based Therapist or other members of the Wraparound Team who note changes in the health and welfare of the youth.

All persons employed by an agency participating in the Waiver program are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or consumers with disabilities. They are also required to complete a Serious Occurrence Report (SOR), DPHHS-MA-129, when warranted. The provider who suspects or witnesses abuse, neglect or exploitation will complete a Critical Incident Report, file a report with the appropriate entity (e.g., DPHHS Child Protective Services or local law enforcement), and send a copy of the report to the Plan Manager who will then send it to the Project Director for quality assurance monitoring. The Project Director provides a quarterly summary to the Children's Mental Health Bureau, Department of Public Health and Human Services (Central Office) staff. In addition, they will consult with Central Office on any serious occurrences not resolved at the local level, patterns that may be reoccurring or necessary system changes as a result of reports. Critical Incident Reports are mandated for incidents in which the youth/family's health and safety are at risk. These reports are sent to the Project Director. The Project Director will become involved in problem solving strategies, as needed, to assist in resolution of issues beyond the scope of the youth/legal guardians and the Plan Managers.

(b) the monitoring and follow-up method(s) that are used; and
The Wraparound Facilitator will meet with the youth/legal guardian to ensure that selected services are provided as outlined in the Plan of Care. These meetings will also provide opportunities to discuss any health and welfare issues reported by the youth/legal guardians. These routine monitoring visits will include a review of the youth's service utilization history, a review of usage and effectiveness of the crisis plan and an evaluation of the quality and effectiveness of services. The Wraparound Facilitator will document any problems that need to be addressed and document the strategy for resolution and report such to the Plan Manager.

The Project Director and/or designee will complete annual quality assurance reviews. This includes reviewing Plans of Care developed by the Wraparound team, CBCL scores, and checking progress toward individual treatment plan goals and objectives. This process will also include interviewing Waiver participants (youth and family members). Through the interview process, the Project Director will determine satisfaction with service providers, Waiver services, and adequacy of treatment. During the annual review process, the Project Director will specifically target a review of the quality of services and assess wait list practices to ensure that Waiver slots are filled in a timely manner. If warranted, the Project Director will address any concerns with the Children's Mental Health Bureau Chief and/or the Developmental Services Division Administrator.

(c) the frequency with which monitoring is performed.
- The Wraparound Facilitator will meet with the youth/legal guardian at least every three months – or more frequently upon request of the legal guardian or other Wraparound Team members - to ensure that selected services are provided as outlined in the Plan of Care. The Wraparound Facilitator will also subject the Plan of Care to annual and periodic reviews and updates to assess the appropriateness, medical necessity and adequacy of the services for the youth. This will include a review of youth access to non-waiver services identified in the Plan of Care.
- The Project Director will complete annual quality assurance reviews.

b. **Monitoring Safeguards.** *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

A licensed mental health professional cannot provide any other waiver or state plan services to the youth they are providing wraparound facilitation for. An agency providing wraparound facilitation must provide freedom of choice for all other waiver and state plan services they provide. The wraparound facilitator and the home

based therapist cannot be from the same agency. In limited situations, the Plan Manager may need to fulfill the role of wraparound facilitation.

The Plan Manager will conduct priodic but not less than annual desk audits to ensure that participants were afforded freedom of choice of providers. The Project Director will receive summary reports from the Plan Manger that the assurance was met or not met. Follow up activities may include formalized reviews of participant records and a corrective action plan if the provider is out of compliance.

Paid claims informtion may be used as a tool to identify trends where there may exist a possibility of non-referral to other agencies.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Service Plans (Plans of Care) address participants' assessed needs(including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. The numerator is the number of annualized plans of care in which all services and goals are based on documented assessed needs. The denominator is the number of annualized plans of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site and off-site record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Annually the State will monitor service plans in accordance with the approved waiver policies.The Plan Manager and/or Project Director will review and approve the plan of care using a checklist to verify compliance with the required components. The numerator is the number of annual Plan of Care checklist items marked with a +. The denominator is the total number of Plan of Care checklist items.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Plans of Care are updated annually or when warranted by changes in the waiver participants needs. The numerator is the number of plans that have been modified within the previous 365 days based on a documented change in the child's needs. The denominator is the total number of annual Plan of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
record review on-site and off-site.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Services are delivered in accordance with the participants plan of care and individual cost plan. The numerator is the number of annual plans for all participants for which documentation is available to support the delivery of services reimbursed. The denominator is the sum of all annual plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS and on-site and off-site record review.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Plan Manager meets with the youth and family and offers choice between waiver services and institutional care. The youth and family signs a Freedom of Choice form which becomes a part of the participants record. The numerator is the number of signed Freedom of Choice forms and the denominator is the number of enrolled youth.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The Plan Manager develops and maintains the list of enrolled waiver providers which is given to the Wraparound Facilitator (WF). The WF will have youth/family sign a form stating they have freedom of choice of providers which will be kept in the participants record. The number is the number of signed forms and the denominator is the number of enrolled participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On and off-site review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified**

		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
As needed, but no less than annually the State will conduct periodic on-site surveys of providers and participants to ascertain the effectiveness of the waiver program. Interviewees are afforded the opportunity to provide recommendations to the State or it's designee regarding waiver services and delivery of services. The data is entered into a state maintained data base which allows the state to extract information that will indicate trends and issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Project Director and the Plan Manager at Children's Mental Health Bureau and/or their designee, are the responsible parties to conduct on-site and off-site record reviews. Where there are any deficiencies involving the plan of care where the wraparound facilitator did not adhere to waiver requirements, a corrective action plan will be initiated by the State. This corrective action plan will include time lines for which the

wraparound facilitator will perform in accordance to waiver requirements. The corrective action plan will require the state to increase on-site reviews of participant records. If the Wraparound Facilitator is unable to meet the requirements of the corrective action plan the State will reassign a wraparound facilitator to the youth. The State's Wraparound Coordinator will be apprised of this wraparound facilitator's inability to comply with the corrective action plan and will be removed from the list of waiver wraparound facilitators.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Legal Guardians/youth will be notified of the fair hearing process by eligibility staff when they complete the Medicaid application process. Legal guardian swill also be notified of the fair hearing process by Megellan Medicaid Services when they receive the choice of Waiver or institutional services during the level of care assessment process. Legal Guardians will be notified of the fair hearing process by Plan Manager when information is provided on choice of providers of service or when there is an adverse action such as a denial, reduction, suspension or termination of services.

Plan Managers and/or the Wraparound Facilitators will provide information regarding the fair hearing process on an on-going basis through their routine involvement with the youth. Resources for Waiver participants in the fair hearing process include the Mental Health Ombudsman, Montana Advocacy Program and personal attorneys of the youth. All documentation that Legal Guardians were provided notification of the fair hearing process will be kept in the respective agency's files.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

a. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

◉ **No. This Appendix does not apply**

○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

a. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

b. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All persons employed by an agency participating in the waiver program are mandatory reporters of suspected abuse, neglect or exploitation of children, elderly, or consumers with disabilities. They are also required to complete a Serious Occurrence Report (SOR), DPHHS-MA-129, when warranted.

At this time, the SOR is not electronically submitted. The SOR must be completed any time an individual's life, health, or safety has been put at risk. This includes all reports for suspected abuse, neglect or exploitation submitted to Adult Protective Services (APS) or Child Protective Services (CPS). In addition, circumstances warranting a SOR include:

- Suspected or known physical, sexual, emotioanl or pscyhological abuse
  Financial exploitation
- Neglect by responsible caregivers
- Sexual harassment by an agency employee or consumer
- Injuries requiring medical intervention to an agency employee or consumer
- An unsafe living or working environment that puts the worker and or waiver participantat risk.

A toll-free Child Abuse Hotline serves as the centralized intake mechanism for reporting suspected child abuse or neglect. It is available statewide (1-866-820-5437). Child abuse or neglect includes actual physical or psychological

harm or the substantial risk of physical or psychological harm to a child by the acts or omissions of a person responsible for the child's welfare; abandonment; and/or exposing a child or allowing a child to be exposed to the criminal distribution of dangerous drugs, the criminal production or manufacture of dangerous drugs, or the operation of an unlawful clandestine laboratory.

Service providers are mandated to immediately refer all suspected abuse, neglect or exploitation to CPS (or APS), to complete the SOR and notify the Wraparound Facilitator and the Plan Manager and the Project Director on the same day the referal is made. The provider agency must document cause and effect of the incident and the action plan to correct or prevent incidents from occurring in the future. The Project Director is responsible for ensuring an appropriate response by the provider agency. The designated state agency (e.g. APS or CPS) will monitor the provider agency to ensure the corrective action plan was activated and identified issues resolved. The Project Director will obtain copies of documentation to ensure compliance has occurred.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information on identifying, addressing, and protecting someone from abuse, neglect and exploitation and how to notify the appropriate authorities will be provided to participants during the development of the Plan of Care. The Wraparound Facilitator will provide this information upon the annual renewal of the Plan of Care. Participants can also access information on the Department of Public Health and Human Services (Department) website. Information on incident management, abuse, neglect,exploitation and consumer protection will be covered as special training topics by the Children's Mental Health Services Bureau in the Central Office for Plan Managers and the Wraparound Facilitator. Training and education for the Plan Managers and Wraparound Facilitator will occur at a minimum on an annual basis and as changes in policies are made.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Child and Family Services Division (CFSD) of Montana's Department of Public Health and Human Services provides protective services to children under 18 who are abused, neglected, or abandoned. This involves receiving and investigating reports of child abuse and neglect, helping families stay together or reunite, and finding placements in foster or adoptive homes when necessary. The CFSD has the legal authority to interview the child, make emergency placements if a child cannot safely remain in the home, and to take physical or legal custody when ordered to do so by the court.

The CFSD operates a toll-free child abuse hotline 24 hours a day, 7 days a week. Centralized Intake specialists screen calls, assess the level of risk to children, and prioritize reports of abuse, neglect, and abandonment according to the urgency with which social workers need to respond. The specialists forward reports of suspected child abuse, neglect, or abandonment to social workers in the appropriate county offices.

Once the Child and Family Services Division of the DPHHS has received a report through the Child Abuse Hotline, their first step is to assess the immediate risk, check for past reports, and contact people who may be able to give more information. The social worker may talk with a child in school or day care or visit with the family. In the case of suspected sexual abuse or when there is a serious physical injury, local law enforcement frequently takes part in the interviews with children. Generally, a Child and Family Services Division (CFSD) staff person or supervisor conducts the investigation and assessment, but a law enforcement officer or the county attorney can also take on this role.

An investigation of child abuse/neglect will result in one of the following determinations:
– Substantiated: based on evidence, it is more probable than not that the abuse or neglect actually occurred;
– Indicated: maltreatment has occurred but the perpetrator is not a person legally responsible for the welfare of the child or is unknown;
– Unsubstantiated: the social worker is unable to demonstrate by a preponderance of evidence as to whether any abuse or neglect occurred;
– Unfounded: there is no reason to suspect abuse/neglect occurred;
– Closed Without Finding: the family cannot be located or the investigation cannot be completed.

Unless a child is in danger and cannot be protected in the home, the goal of the CFSD is to keep families together. If

the child is in immediate danger, the CFSD social worker may use the authority of a Petition for Emergency Protective Services to immediately remove the child. In that case, the child may be placed with the child's non-custodial parent or a member of the extended family, in a licensed foster home, group home or shelter care facility.

Temporary Investigative Authority (TIA) is ordered by a judge, and gives CFSD the legal right to conduct an in-depth investigation. A TIA can be ordered for a maximum of 90 days, and does not confer legal custody. A Guardian Ad Litem (GAL) and/or Court Appointed Special Advocate (CASA) will be appointed to represent the child whenever the court takes action. After a TIA is ordered, the social worker will work with the family to resolve the problems that led to removing the child. The family has 90 days to complete the requirements listed in the plan. At the end of the 90 days, the judge must order Temporary Legal Custody if the child cannot be safely returned to the home.

Temporary Legal Custody (TLC) confers the right and responsibility for the care, custody and control of the child on a temporary basis to CFSD. The Court usually orders TLC for six months, but this period may be extended for an additional six months if the Court believes that more time is required to complete the treatment plan. Successful completion of a treatment plan is necessary for reunification.

A permanency plan hearing must be held no later than 12 months after a Court has found the child to be abused or neglected, 14 months after a child is removed from the home, or whichever comes first. At this hearing a report is submitted to the Court by CFSD and the Guardian ad Litem or CASA, stating the permanency plan for the child.

Termination of Parental Rights (TPR) and Permanent Legal Custody (PLC): According to state and federal law, if a child has remained in court-ordered out-of-home care for 15 of the past 22 months, the state is required to file for Termination of Parental Rights (TPR) and Permanent Legal Custody (PLC).

Out-of-home placements: If a child is in immediate danger, the child may be placed outside the home, either permanently or temporarily. District court judges must approve all out-of-home placements.

Referrals are made, when necessary, to local law enforcement or other entities. Referrals to local law enforcement include
illegal activities, theft, embezzlement and incidents involving significant abuse.

Incidents and events outside the scope of APS, CPS or local law enforcement authority are reported to the pertinent provider agency. The agency investigates the incident and provides follow-up, when needed. The provider agency documents the scope of the incident, the incident's cause and effect, and work with the consumer to develop an action plan to correct or prevent the incident from reoccurring in the future.

This information is captured on a Serious Occurrence Report (SOR). A copy of the SOR must be provided to the Plan Manager within 10 days. The Plan Manager will follow up on the SOR to ensure that the incidents are being addressed and resolved as they occur and during the quality assurance reviews. The Plan Manager is responsible for insuring an appropriate and timely
response is provided by the provider agency. On the SOR form there is a section where the Plan Manager may comment on the incident and mark any follow-up action taken, including providing training, case conference, and/or sanctions.

All referrals where there is suspected abuse, neglect, exploitation or other unlawful activity will be immediately reported to the appropriate authority. The Wraparound Services Team will be made aware of the referrals through their interactions with Waiver enrollees and families and provider agencies. The Plan Manager and/or the Wraparound Facilitator will follow up with the appropriate authority, including Child Protective Services, to ensure the health and safety of waiver consumers. The authority responsible for the investigation may not be able to share investigation results due to confidentiality of the investigation. The Plan Manager will monitor the services provided to Waiver enrollees and make changes within the Plan of Care and will work with Waiver services providers, should the investigation involve providers. The Wraparound Team will be apprized of all serious events. The Plan Manager will be responsible for tracking serious events and bringing situations to the attention of the Children's Mental Health Bureau Chief and Quality Assurance Manager. The Bureau Chief and Quality Assurance Manager will ensure there is adequate training and monitoring of specific providers in the event there appears to be a common pattern being established in any of the Waiver sites.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Youth, families, providers, and regional staff (Plan Managers) will have the opportunity to provide input on developing effective and strategic prevention strategies. The CMHB will have quarterly meetings and/or telephone conference calls with the Plan Managers to discuss the management of critical incidents and events. The CMHB will meet more frequently with individual Plan Managers, as warranted. At a minimum, CMHB, Wraparound Facilitators and Plan Managers will meet annually to discuss the management of critical incidents and events. Training delivered by staff from APS, CPS and law enforcement may be included in the annual meetings as in-service training to Wraparound Facilitators and Plan Managers.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The Wraparound Facilitator, waiver providers and Plan Manager will monitor all PRTF Waiver youth and families and will report any unauthorized use of restraints and restrictive interventions to the Quality Assurance Division for investigation and to the Project Director. Concurrently, a Serious Occurrence Form will be completed documenting the incident. The Wraparound Facilitator will complete regular visits to all PRTF Waiver participants to ensure the health and safety of waiver youth.

○ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Wraparound Facilitator will monitor at a minimum quarterly, all PRTF Waiver youth and families and will report any unauthorized use of restraints and restrictive interventions to the Quality Assurance Division for investigation and to the Plan Manager and/or Project Director. Concurrently, a Serious Occurrence Form will be

completed documenting the incident. The Wraparound Facilitator will complete regular visits to all PRTF Waiver participants to ensure the health and safety of waiver youth and families.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

a. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Staff in licensed therapeutic group homes, youth shelters or group homes, provide medication management for self- administered medication. They are responsible for keeping track of medication and ensuring the youth take their medication and ensuring that the youth take medication as prescribed. Medication is kept in a lock box thus restricting access by other youth. Staff in licensed facilities will refer all medication errors to their respective management and complete the Serious Occurrence Report. Management will work with the staff regarding waiver youth.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DPHHS Quality Assurance Division, Licensing Bureau ensures the appropriate management of medication during quality assurance reviews. The point-of-scale system used by pharmacy providers has a set of built-in edits to inform the pharmacist of potential contraindicated effects such as drug-to-drug interaction and therapeutic duplications. There is also a prior authorization process based on clinical criteria established by the Drug Utilization Review Board for the department. Through periodic reviews, the Wraparound Facilitator will monitor that youth on the waiver receive their medication as prescribed and will report any mismanagement, harmful practices or crimes to the appropriate authorities. The Wraparound Facilitator will

be required to complete necessary documentation to report any serious occurrences. Oversight and follow-up are the responsibility of the Quality Assurance Division, Licensing Bureau.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- (●) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
  Do not complete the rest of this section

i. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Waiver providers working with participants are mandatory reporters of suspected abuse, neglect and exploitation of children. Waiver providers monitor the health and welfare of participants. The numerator is the number of substantiated cases referred to Centralized Intake for Child by waiver providers. The denominator is the number of all referrals made to Centralized Intake by waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Child and Family Services Division will provide information to the CMHB regarding the number of substantiated cases and number of all referrals made to Centralized Intake by waiver providers.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: Waiver Providers	☐ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
The Plan Manager will review all Serious Occurrence Report (SOR) within 10 days of receipt. The numerator is the number of SOR's reviewed within 10 days. The denominator are all SOR's submitted to the Plan Manager.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =

☑ **Other** Specify: Waiver Providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The system improvement processes followed in response to aggregated, analyzed information collected on incident management, abuse, neglect and exploitation and consumer protection will be covered as special training topics annually for Plan Managers and Wraparound Facilitators.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Plan Manager will work with Waiver service providers to ensure proper training. The Plan Manager and/or Project Director will work with the Waiver provider to develop a corrective action plan. The Plan Manager and/or Project Director will ensure there is adequate training and monitoring of specific providers in the event there appears to be a common pattern being established in any of the Waiver sites.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to

undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Management Strategy will involve strategies designed to collect and review data on quaility assurance meansures gathered from numerous participants in the Wraparound Services process, includidng providers and youth and family members. A Quality Management Committee (QMC) comprised of the Project Director, Plan Manager (s), Fiscal Analyst, Children's Mental Health Bureau Chief, Megellan Medicaid Administration personnel, representative of a family that has a child with SED, and other (to be identified) will meet quarterly, or as frequently as necessary, to identify trends, systemic issues, gaps and will create the remedial interventions necessary. The QMC will monitor the discovery activities and submitted information from the Plan Managers; to evaluate and make recommendations to the State to address provider or system deficiencies. The Committee will recommend to the State a corrective action plan.
Annual performance audits will be conducted by the Project Director or designee, to assure adherence to the waiver policies, practices, and guidance; and to identify any deficiences and/or trends. Practices are anticipated to continuously evovle in response to emerging standards, best practices and identified issues. The approach to ensure effectiveness of the QMS will include process based evaluation as well as on-going review of fiancial records including expenditures. The monitoring practices will be designed to assess systems level functioning which will be utilized to make changes needed to ensure success when the waiver is implemented in additional counties.
Concurrently, the Plan Manager and Project Director or designee, will conduct internal audits of participant records to ensure that files include the necessary documentation to support the identified needs of the youth and family. Plans of Care must be accurate and complete; services must be aligned to address identified needs; the cost sheet must match the services provided; and all required information must be included in the file.
In addition to the MDS the State requires certification (or working toward certification) for Wraparound Facilitators. The Plan Manager is responsible for direct monitoring of the Wraparound Facilitator to ensure wraparound fidelity and adherence to wraparound principles.
The State will initiate a survey annually, conducted in person, to gather information from youth, families and providers regarding the efficacy of the program. Interviewees will be afforded the opportunity to provide input towards the development of program and system improvements.
When the state identifies the need to amend the waiver and the Administrative Rules of Montana, public comment will be sought from providers, families, waiver participants, interested parties and the public via the administrator rule hearing the written comment.

On CMHB website the state will post information communicating the results of the audit and survey.

These system improvement activities apply to Level of Care, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority and Financial Accountability. However, the information we gather for the aggregated analyzed, discovery and remidiation process varies across assurances.
The Department does not do Criminal Background checks however, ACS, our fiscal agent, with each individual enrollment goes through a proceedure of checking with licensing entities within the Department of Labor and Industries, the Excluded Indivdiual and Entities List,and Medicare exclusion lists. The hard copy of the Licensee Lookup System indicates any adverse action or information regarding the enrollee and may prevent that individual from being enrolled as a PRTF Waiver Provider. All contracts issued by the Department goe through a review process to insure the potential contractor is not on the Federal Debarment List.

The Department has establish qualifications for staff who are participating in the PRTF Waiver. Minimum qualifications for the Plan Manager include a Bachelor's degree in the Human Service Field and at least three years experience in the Children's Mental Health system. The Project Director must have at least a Bachelor's degree in the human service field however, a Master's degree is preferred and experience in supervision and at least three years experience in the Children's Mental Health System. The minimum qualification for the PRTF Waiver Fiscal Analyst include a Bachelor's degree in business, finance, accounting, health administration and/or public administration and two years of work related experience.
The Department does not do Criminal Background checks however, ACS, our fiscal agent, with each individual enrollment goes through a proceedure of checking with licensing entities within the Department of Labor an Industries, the Excluded Individual and Entities List, and Medicare exclusin lists. The hard copy of the Licensee Lookup System indicates any adverse action or information regarding the enrollee and may prevent that individual from being enrolled as a PRTF Waiver Provider. All contracts issued by the Department go through a review process to ensure the potential contractor is not on the Federal Debarment List.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: as needed

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

On a daily basis staff is involved in the collection, monitoring and analyzing of aggregated data and system design changes. Staff includes the Plan Manager, Project Director and where appropriate the Quality Management Committee. Primarily the Plan Managers are responsible for the collection and aggregation of data and the development of annual summary reports for use by system change decision maker's. Collection and monitoring of data is an on-going process and as needed will be used to improve the waiver program. The Quality Management Committee will review all system design changes and provide imput as to the effectiveness of the change. The Project Director is responsible for overseeing implementation of all system changes and ensuring the timely collection and aggregation of performance data and in the generation of helpful and accurate annaul summary reports compiled by Plan Managers.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy will be evaluated annually by the Project Director and/or the Quality Management Committee, at such time the summary reports are generated by the Plan Managers. In addition to quarterly QMC meetings the State may request additional QMC meetings for the purpose of generating recommendations to improve system efficiency and consistency. Recommendations will be shared with management staff for the purpose of recommending changes. The State will remain responsive to the concerns of enrollees and providers and others in updating performance measures, the processes used to collect information, and the best ways to summarize and share information with interested individuals and entities.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Public Health and Human Services (Department) provides financial oversight to assure that claim coding and payment are in line with the waiver reimbursement methodology. The Department does not require waiver providers to secure an independent audit of their financial statements. Paid claims reports will be reviewed by the Children's Mental Health Bureau (CMHB), Developmental Services Division of the Department on at least a monthly basis (or as needed). These reports will depict the services utilized, the number of youth using each service, the number of units utilized, and the total dollar amount paid for each service. As a part of the quality assurance reviews, financial accountability will be assessed. Charts will be reviewed by CMHB staff to ensure that no payments were made for waiver services when a youth was permanently or temporarily discharged from waiver services. The Audit and Compliance Bureau of the Department will conduct financial audits upon request of the Developmnental Services Division, Children's Mental Health Bureau. The Audit and Compliance Bureau is further mandated to perform reviews for any and all areas of suspected over payments and as such, may be completing financial audits relative to the PRTF waiver providers without being directly referred by the CMHB. Audits will be conducted in compliance with the single state audit act.

Plan Managers and the Project Director will be required to conduct internal audits of their records to ensure the waiver participants' files include the necessary documentation to support the youth's identified needs. The plans of care must be accurate and complete; services must be aligned to address the identified needs; the cost sheet must match the services provided; and all required information must be included in the file. These internal audits are performed by the Plan Managers and the Project Director on a quarterly basis for the initial two years of this new waiver in the first site. Subsequent internal audits of the first site will occur semi-annually. As other sites become operational with the waiver, the internal audits will follow the same course as the initial site. The goal after all sites are operational is to complete the internal audits annually, rotating sites within the year to accommodate all site visits. The CMHB Chief will be kept apprised of the internal audit results. Any deficiencies will be addressed by the CMHB Chief and the Project Director.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Paid claims for waiver services documented in the MMIS are based on waiver services billed using HCPCS codes, and modifiers in accordance with the approved waiver. All

waiver services are authorized in the Plan of Care and properly billed by a qualified waiver provider. The numerator is the number of paid waiver claims. The denominator is the number of waiver claims submitted(paid and denied).

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
MMIS data base

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Plan Managers and Project Director will conduct at least annual internal audits of participant records to ensure the waiver services are aligned to address identified needs and the cost sheet matches services provided and paid claims support services authorized and provided.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Children's Mental Health Bureau will provide ongoing training to all waiver providers identified as having issues will billing to ensure accuracy of coding and proper billing. If there is a waiver provider experiencing issues with billing deficiency, Children's Mental Health Bureau will meet with the provider until resolution has occurred. The department's fiscal agent, ACS, holds two provider fairs annually where waiver providers will have the opportunity to learn proper billing procedures and to discuss any billing issues.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: ACS, fiscal agent	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Payments for waiver services will be consistent with efficiency, economy and quality of care and will be sufficient to enlist enough providers. Services will be reimbursed via fee for service; there will be no interim rates, no prospective payments, and no cost settlements. The Department of Public Health and Human Services (Department) will take into consideration the difficulty of care factors for some of the waiver services.
As we expand to the surrounding counties to existing core sites, we acknowledge the provider pool will be limited. Therefore the amendment for waiver year three proposes to implement a geographical factor for Home-based Therapy, Wraparound Facilitation, Peer-to- Peer Support Specialist and Family Support Specialist. The rate is established for the providers specificed above who must travel a distance more than 35 miles from their agency to the youth's home. Information regarding the HCBS services, definitions and rates of reimbursement will be available on the Department's web site and through ACS, the Department's fiscal agent. The Plan Manager will have this specific information in hard copy format to provide to waiver enrollees and their families.
Information regarding the HCBS services, definitions and rates of reimbursement will be available on the Department's web site and through ACS, the Department's fiscal agent. The Plan Manager will have this specific information in hard copy format to provide to waiver enrollees and their families.

The rate setting methodology will be defined in the Administrative Rules of Montana. The rule process solicits written and oral comments from the public through a formal hearing.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The state's MMIS has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. Plan Managers will prior authorize all waiver services in the youth's plan of care. These prior authorizations will be submitted to the state's fiscal intermediary, ACS. The quality assurance plan includes a process to verify that payments for services were made in accordance with the plan of care and no waiver services were paid for a youth who was discharged from the waiver.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The state's MMIS has a recipient eligibility system that verifies eligibility for Medicaid and the waiver. The Plan Managers will prior authorize all waiver services in the youth's plan of care. These prior authorizations will be submitted to the state's fiscal intermediary, ACS. The quality assurance plan includes a process to verify that payments for services were made in accordance with the plan of care and no waiver services were paid for a youth who was discharged from the waiver.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a.

Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Respite providers for the PRTF waiver will be notified that the waiver will not cover the cost of room and board for youth on the waiver.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a.

Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**

○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ **Nominal deductible**
☐ **Coinsurance**
☐ **Co-Payment**
☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care:

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	12512.00	11368.00	23880.00	40162.00	2997.00	43159.00	19279.00
2	28839.66	8475.00	37314.66	76851.00	6325.00	83176.00	45861.34
3	31143.63	8734.00	39877.63	76851.00	6325.00	83176.00	43298.37
4	30869.50	9170.00	40039.50	78390.00	5649.00	84039.00	43999.50
5	30952.50	9629.00	40581.50	78390.00	5649.00	84039.00	43457.50

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		PRTF	
Year 1	20	20	
Year 2	40	40	
Year 3	100	100	
Year 4	200	200	
Year 5	200	200	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for Waiver year two through Wavier year five is 253 days as approved in the original application.

The PRTF waiver will provide an opportunity to stabilize youth entering the waiver program and develop the wraparound services to assist the youth and family in self sufficiency.

This average length of stay figure was kept static and upon completion of the 372 report, if significant differences are reflected, an amendment will be requested from the Centers for Medicare and Medicaid Services.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The waiver services and the fees times the utilization per enrollee provided the information for Factor D. Department staff projected utilization based on history of Wavier year one and discussions with providers and contractors. Average length of stay was taken into consideration for Factor D.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The state plan Medicaid services for waiver enrollees was computed using paid claims data for youth with a diagnosis of Serious Emotional Disturbance and their utilization of services. The projected utilization was applied to the waiver enrollees. Average length of stay was taken into consideration for Factor D'. The calculation for D' does not include costs of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provisions of Medicare Part D as most of the waiver enrollees will not be Medicare eligible.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G for waiver year two through Waiver year five is based on the new Medicaid daily rate of $309.84 x 253 days. This is the Psychiatric Residential Treatment Facility rate for the Montana providers based rate.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G' for each waiver year two through waiver year five is an average of the three Montana PRTF's ancillary rate ($22.33 x 253 days).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Respite Care	
Caregiver Peer-to-Peer Support	
Consultative Clinical and Therapeutic Services	
Customized Goods and Services	
Education and Support Services	
Family Support Specialist	
Home-based Therapist	
Non-emergency Transportation	
Wraparound Facilitator	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						66538.80
Respite Care 15 minutes	15 minutes	0	0.00	0.01	0.00	
Respite Care per diem	per diem (per 24 hou	20	1098.00	3.03	66538.80	
Caregiver Peer-to-Peer Support Total:						0.00
Caregiver Peer-to-Peer Support per diem	per diem (per day)	0	0.00	0.01	0.00	
Caregiver Peer-to-Peer Support Direct Service	15 minute	0	0.00	0.01	0.00	
Geographic factor	Mile	0	0.00	0.01	0.00	
Consultative Clinical and Therapeutic Services Total:						32000.00
Consultative Clinical and Therapeutic Services, psychiatrist	per consultation	20	8.00	120.00	19200.00	
Consultative Clinical and Therapeutic Services, primary physician	per consultation	20	8.00	80.00	12800.00	
Customized Goods and Services Total:						4000.00
Customized Goods and Services	per family/year	20	1.00	200.00	4000.00	
Education and Support Services Total:						1500.00
Education and Support Services	per series (pkg)	20	1.00	75.00	1500.00	
Family Support Specialist Total:						0.00
Family Support Specialist per diem (day)	per diem (per day)	0	0.00	0.01	0.00	
Family Support Specialist direct service	15 minute	0	0.00	0.01	0.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
Home-based Therapist Total:						144760.00
Home-based Therapist direct service	15 minutes	20	232.00	29.00	134560.00	
Home-based Therapist per diem session	per diem (Per day)	20	17.00	30.00	10200.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
Non-emergency Transportation Total:						1443.20
Non-emergency Transportation	Mile	20	328.00	0.22	1443.20	
Wraparound Facilitator Total:						0.00
Wraparound Facilitator	15 minute	0	0.00	0.01	0.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
				GRAND TOTAL:		250242.00
				Total Estimated Unduplicated Participants:		20
				Factor D (Divide total by number of participants):		12512.00
				Average Length of Stay on the Waiver:		253

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						219808.20
Respite Care 15 minutes	15 minute	30	1098.00	3.03	99808.20	
Respite Care per diem	per diem (24 hours)	40	15.00	200.00	120000.00	
Caregiver Peer-to-Peer Support Total:						95375.00
Caregiver Peer-to-Peer Support per diem	per diem (per day)	35	10.00	10.00	3500.00	
Caregiver Peer-to-Peer Support Direct Service	15 minute	35	350.00	7.50	91875.00	
Geographic factor	Mile	0	0.00	0.01	0.00	
Consultative Clinical and Therapeutic Services Total:						32000.00
Consultative Clinical and Therapeutic Services, psychiatrist	per consultation	20	8.00	120.00	19200.00	
Consultative Clinical and Therapeutic Services, primary physician	per consultation	20	8.00	80.00	12800.00	
Customized Goods and Services Total:						30000.00
Customized Goods and Services	per family/year	30	1.00	1000.00	30000.00	
Education and Support Services Total:						3000.00
Education and Support Services	per series (pkg)	40	1.00	75.00	3000.00	
Family Support Specialist Total:						211000.00
Family Support Specialist per diem (day)	per diem (per day)	40	10.00	20.00	8000.00	
Family Support Specialist direct service	15 minute	40	350.00	14.50	203000.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
Home-based Therapist Total:						450960.00
Home-based Therapist direct service	15 minute	40	366.00	29.00	424560.00	
Home-based Therapist per diem session	per diem (per day)	40	22.00	30.00	26400.00	
				GRAND TOTAL:		1153586.40
				Total Estimated Unduplicated Participants:		40
				Factor D (Divide total by number of participants):		28839.66
				Average Length of Stay on the Waiver:		253

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Geographical Factor	Mile	0	0.00	0.01	0.00	
Non-emergency Transportation Total:						1443.20
Non-emergency Transportation	mile	20	328.00	0.22	1443.20	
Wraparound Facilitator Total:						110000.00
Wraparound Facilitator	15 minute	40	200.00	13.75	110000.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
				GRAND TOTAL:		1153586.40
				Total Estimated Unduplicated Participants:		40
				Factor D (Divide total by number of participants):		28839.66
				Average Length of Stay on the Waiver:		253

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						586155.20
Respite Care 15 minutes	15 minutes	80	1098.00	3.03	266155.20	
Respite Care per diem	per diem (24 hours)	100	16.00	200.00	320000.00	
Caregiver Peer-to-Peer Support Total:						257250.00
Caregiver Peer-to-Peer Support per diem	per diem (per day)	90	22.00	10.00	19800.00	
Caregiver Peer-to-Peer Support Direct Service	15 minute	90	350.00	7.50	236250.00	
Geographic factor	Mile	2	1200.00	0.50	1200.00	
Consultative Clinical and Therapeutic Services Total:						96000.00
Consultative Clinical and Therapeutic Services, psychiatrist	consultation	60	8.00	120.00	57600.00	
Consultative Clinical and Therapeutic Services, primary physician	consultation	60	8.00	80.00	38400.00	
Customized Goods and Services Total:						85000.00
				GRAND TOTAL:		3114363.20
				Total Estimated Unduplicated Participants:		100
				Factor D (Divide total by number of participants):		31143.63
				Average Length of Stay on the Waiver:		253

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Customized Goods and Services	family/year	85	1.00	1000.00	85000.00	
Education and Support Services Total:						7500.00
Education and Support Services	per series (pkg)	100	1.00	75.00	7500.00	
Family Support Specialist Total:						587750.00
Family Support Specialist per diem (day)	per diem(per day)	100	22.00	20.00	44000.00	
Family Support Specialist direct service	15 minute	100	375.00	14.50	543750.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
Home-based Therapist Total:						1127400.00
Home-based Therapist direct service	15 minutes	100	366.00	29.00	1061400.00	
Home-based Therapist per diem session	per diem (per day)	100	22.00	30.00	66000.00	
Geographical Factor	Mile	0	0.00	0.01	0.00	
Non-emergency Transportation Total:						3608.00
Non-emergency Transportation	mile	50	328.00	0.22	3608.00	
Wraparound Facilitator Total:						363700.00
Wraparound Facilitator	15 minute	100	250.00	14.50	362500.00	
Geographical Factor	Mile	2	1200.00	0.50	1200.00	
				GRAND TOTAL:		3114363.20
				Total Estimated Unduplicated Participants:		100
				Factor D (Divide total by number of participants):		31143.63
				Average Length of Stay on the Waiver:		253

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						1055867.50
Respite Care 15 minutes	15 minutes	125	1098.00	3.03	415867.50	
				GRAND TOTAL:		6173908.50
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		30869.50
				Average Length of Stay on the Waiver:		253

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care per diem	per diem (24 hours)	200	16.00	200.00	640000.00	
Caregiver Peer-to-Peer Support Total:						510275.00
Caregiver Peer-to-Peer Support per diem	per diem (per day)	175	22.00	10.00	38500.00	
Caregiver Peer-to-Peer Support Direct Service	15 minute	175	350.00	7.50	459375.00	
Geographic factor	Mile	8	3100.00	0.50	12400.00	
Consultative Clinical and Therapeutic Services Total:						200000.00
Consultative Clinical and Therapeutic Services, psychiatrist	per consultation	125	8.00	120.00	120000.00	
Consultative Clinical and Therapeutic Services, primary physician	per consultation	125	8.00	80.00	80000.00	
Customized Goods and Services Total:						180000.00
Customized Goods and Services	family/year	180	1.00	1000.00	180000.00	
Education and Support Services Total:						11250.00
Education and Support Services	Per Session	150	1.00	75.00	11250.00	
Family Support Specialist Total:						1196300.00
Family Support Specialist per diem (day)	per diem (per day)	200	22.00	20.00	88000.00	
Family Support Specialist direct service	15 minute	200	375.00	14.50	1087500.00	
Geographical Factor	Mile	8	5200.00	0.50	20800.00	
Home-based Therapist Total:						2275600.00
Home-based Therapist direct service	15 minutes	200	366.00	29.00	2122800.00	
Home-based Therapist per diem session	per diem (per day)	200	22.00	30.00	132000.00	
Geographical Factor	Mile	8	5200.00	0.50	20800.00	
Non-emergency Transportation Total:						7216.00
Non-emergency Transportation	mile	100	328.00	0.22	7216.00	
Wraparound Facilitator Total:						737400.00
Wraparound Facilitator	15 minute	200	250.00	14.50	725000.00	
Geographical Factor	Mile	8	3100.00	0.50	12400.00	
				GRAND TOTAL:		6173908.50
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		30869.50
				Average Length of Stay on the Waiver:		253

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:						1055867.50
Respite Care 15 minutes	15 minutes	125	1098.00	3.03	415867.50	
Respite Care per diem	per diem (24 hours)	200	16.00	200.00	640000.00	
Caregiver Peer-to-Peer Support Total:						513375.00
Caregiver Peer-to-Peer Support per diem	per diem (per day)	175	22.00	10.00	38500.00	
Caregiver Peer-to-Peer Support Direct Service	15 minute	175	350.00	7.50	459375.00	
Geographic factor	Mile	10	3100.00	0.50	15500.00	
Consultative Clinical and Therapeutic Services Total:						200000.00
Consultative Clinical and Therapeutic Services, psychiatrist	per consultation	125	8.00	120.00	120000.00	
Consultative Clinical and Therapeutic Services, primary physician	per consultation	125	8.00	80.00	80000.00	
Customized Goods and Services Total:						180000.00
Customized Goods and Services	family/year	180	1.00	1000.00	180000.00	
Education and Support Services Total:						11250.00
Education and Support Services	Per Session	150	1.00	75.00	11250.00	
Family Support Specialist Total:						1201500.00
Family Support Specialist per diem (day)	per diem (per day)	200	22.00	20.00	88000.00	
Family Support Specialist direct service	15 minute	200	375.00	14.50	1087500.00	
Geographical Factor	Mile	10	5200.00	0.50	26000.00	
Home-based Therapist Total:						2280800.00
Home-based Therapist direct service	15 minutes	200	366.00	29.00	2122800.00	
Home-based Therapist per diem session	per diem (per day)	200	22.00	30.00	132000.00	
Geographical Factor	Mile	10	5200.00	0.50	26000.00	
Non-emergency Transportation Total:						7216.00
				GRAND TOTAL:		6190508.50
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		30952.50
				Average Length of Stay on the Waiver:		253

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-emergency Transportation	mile	100	328.00	0.22	7216.00	
Wraparound Facilitator Total:						740500.00
Wraparound Facilitator	15 minute	200	250.00	14.50	725000.00	
Geographical Factor	Mile	10	3100.00	0.50	15500.00	
				GRAND TOTAL:		6190508.50
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		30952.50
				Average Length of Stay on the Waiver:		253